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The Canadian Nurse

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Primitive Midwifery

By MARY CHADWICK, London, England

It seems generally thought that among primitive folk child-bearing is a simple affair and that midwives are both unknown and unnecessary: but this is scarcely true. In many countries and among various tribes, parturition is recognized as an exceedingly hazardous enterprise for the mother, in which she may easily lose her life, and has thus become surrounded with magical rites and ceremonies. They are used to drive away evil spirits who may be hovering near, waiting to injure mother or new-born child. Men and boys hide themselves in the woods, and sometimes the woman is left alone in her greatest need or she may be attended by the old women, or even men, who crowd around her. This, however, is not always the case. Among some tribes, midwifery is considered an honourable profession and is adopted and practised by the old women of the tribe, who acquire considerable proficiency in their special technique.

The slow increase of population in uncivilized countries is due chiefly to the habit of abortion, and also to the lack of experienced midwives. In many parts, foeticide is practised quite openly as a preventive measure against having to rear large families under adverse circumstances and also to hide the evidence of extra-marital cohabitation. Foeticide may be either practised by the woman herself, or the professional midwife is called in to assist; while in some districts the mother gives her daughter the necessary drugs and instructions how to use them upon her marriage. Abortion may often be caused by the work in the fields as well as by the use of drugs and poisons, although the latter, whilst having the desired effect, frequently cause the death of the mother as well as that of the infant.

We have learnt something about the condition of midwifery from the records of missionaries and in the more recent ethnological works. Chiefly should be mentioned in this connection that admirable work by W. D. Hambly, Origins of Education amongst Primitive Peoples, which gives a most comprehensive account of the customs in use in different parts of the world among women during pregnancy, the lying-in period, as well as during child-birth itself. One of the additional attractions of this book is that it is profusely illustrated by excellent and often quite unique photographs.

Should we summarize what is to be found among these various accounts, we find the following customs to be most prevalent. Old women act as midwives, as a rule, often without training or preparation: external massage and magical rites are the favourite methods of inducing labour in a difficult confinement, internal manipulations are seldom used, and the report of R. W. Felkin, of a case of Caesarian Section among the negroes of Uganda, appears to be unique. Usually the pains seem to be of quite short duration, some two or three hours. In order to prevent the child rising, a cloth is bound tightly round the body of the parturient woman. In Borneo the husband is allowed to remain in the room, but is hidden from his wife by a screen. The umbilical cord is cut with a bamboo knife, and then the women anxiously await the appearance of the after-birth. Should this fail to appear as soon as expected, the cord is fastened to an axe

that is thrust into the ground to prevent its return into the body. Among nearly all primitive folk the afterbirth is connected with strange beliefs and magical properties. It is frequently treated as a second child, or the baby's shadow or double. A ceremonious burial is given to it or in some cases it is thrown into a river or the sea. Among the Mafulu, the mother gives the new-born infant some water to drink at the same time; if it partakes, it is considered a good omen, but otherwise it may also be drowned. Frequently a childless woman accompanies this little party and adopts the infant should its life be imperiled by refusing the draught.

Primitives regard the caul with as much or even greater superstitious reverence than that which still survives among some civilized peoples to this day. They treat it with the utmost respect and preserve it carefully. Many tribes dry it and powder it for use as medicine in the later life of its owner.

In the Easter Islands men used to act exclusively as the midwives, but they have almost died out now and their place has been taken by women. Birth here occurs in a standing position with the legs outspread. The man or woman stands behind the patient and puts both arms round her, the hands touching and the thumbs pointing downwards. The abdomen is then massaged with a circular, downward motion until the birth occurs. When this is sufficiently advanced, the child is withdrawn and the cord bitten through. Occasionally this ceremony is performed by the child's father, but not in every case. In many parts of Australia the cord is severed with an obsidian knife, and one commonly remarks that some obsolete instrument is used in this ceremony that has otherwise fallen into disuse. When the child has been safely delivered, the woman lies upon a mat in her hut, and warm, flat, fairly heavy stones are laid upon her abdomen, which practice is thought to account for the women in the Easter Islands retaining a good figure even after difficult confinements. The infant is kept at the breast about a year. In other parts, where food suitable for a baby is not to be had, it is no uncommon thing for a mother to suckle her child for two or three years.

The Jao tribe, in East Africa, seem to have been in the habit of using some particularly clumsy method of cutting the cord, for umbilical rupture is no rare occurrence, and has even become regarded as an ideal of beauty in some districts. Among the Hottentots, during a difficult birth, the women strive to widen the vulva, and should their attempt prove unsuccessful, they deliberately tear the perineum to the anus. No subsequent care is taken to repair this wound, as it might then tend to hinder the passage of the next child into the world. The Brazilian women go into the bush and bite through the cord of their children themselves. It is possible to find in different parts of the world every conceivable position for the parturient woman, from that described above, to sitting or squatting, upon all fours, standing upon the head, supported by attendant women, lying upon the back or side, kneeling or resting upon the knees of her husband, which is uncommon, as the men of the tribe are usually excluded upon grounds of the uncleanness of the woman, until certain rites have been performed.

A curious custom is prevalent in many parts of Australia, where the women usually do the heavy work of the fields. After the birth of the child, the woman returns to her work and the **husband goes to bed.** Presents are brought to him and enquiries made concerning the health of himself and the newborn infant. He remains in this state, called **the Couvade,** until the stump of the umbilicus has fallen off, is very strictly dieted and only allowed to leave the hut to satisfy physical

needs. It is usual even should the father not remain in bed, for both parents to abstain from certain foods during the lying-in period, since it is believed that the child will acquire the characteristics of any creature consumed by them at that time, and that inappropriate food will upset the baby and give it indigestion. Medicine prepared for the infant is swallowed by the parents.

It is supposed that many of the most primitive tribes in Australia are not aware of any connection between cohabitation, pregnancy and child-birth. Among the Arunta people, the child is supposed to enter the mother as a tiny spirit, which was hiding in some stone, tree or even flower hanging over the stream when she went down to bathe. The spirit, who was that of an ancestor, was anxious to enter this world once more, and so crept into the body of the woman and in due course was born again.

Very many superstitions surround the woman who dies in labour. When the pains are very great or unduly protracted, the news spreads rapidly in the village and the people are filled with fear. Should death occur, the corpse is buried with all haste by the old men and women and the hut often burnt to the ground to get rid of the evil spirits who might otherwise haunt the place. Twins may be regarded as a good or bad omen. Some tribes hold them to be unlucky, and invariably kill the second or the more quiet one, or bury it alive near the hut. Sometimes we find that it is the custom to kill and eat the first-born of every woman, to bring luck to the rest of the tribe and to increase the physical health of all who partake.

In all ways, however, when we are raising our hands in horror at the numbers of deaths that occur among lying-in woman and newly born infants, let us remember these primitive tribes and consider how far worse is their lot with such inexperienced nursing and feel rather thankful that after all times are better than they were and that the advance of science and investigation has at least taught us something in the way of looking after the mother and the child.

NEW YEAR'S GREETINGS TO THE CHINESE NURSES FROM THE NURSES OF CANADA

The nurses of Canada send New Year's greetings to the Chinese nurses in which are mingled sympathy, admiration, appreciation and hope.

The sympathy of the Canadian nurses goes out to the Chinese nurses for their great disappointment in having to relinquish the 1929 Congress of the International Council of Nurses, due to events over which the Chinese nurses had no control. The efforts being put forth by the Chinese nurses to have made the Congress of 1929 in their country a great success fills their Canadian sisters with admiration, and the generous spirit in which the Chinese nurses wish success to those on whose shoulders the agreeable task of organizing the convention falls, arouses deepest appreciation.

It is the earnest hope of the Canadian nurses that in the near future peace and happiness will come to China. Canada also hopes to have the honour and the pleasure of entertaining many of the Chinese nurses in Montreal in 1929.

Editorials

Let us all wish each other a happy and busy New Year, and without more ado, let us all roll up our sleeves.

The Memorial was a big project successfully achieved, so that we Canadian nurses have a precedent as to what our own efforts will do when we decide to pull together.

The year 1928 brings to us two challenges. One is the Congress of the International Council of Nurses, which will be held in Montreal in the summer of 1929 and which Canadian nurses must make a success; the other is a scientific survey of nursing in Canada.

An international convention is a costly business as our friends the Finnish nurses very well know. They have set a high standard in organization of arrangements and in the provision of entertainment. They felt the honour of their country was at stake. So will it be in the case of Canada. A year before the international meeting in Helsingfors, Finnish nurses commenced to study English so that they might be the better hostesses. Think of the effort in mastering a foreign language in one year for this purpose! Their organization was set up exactly one year before the meeting, and this may have accounted for the smoothness with which the wheels went round during the strain and stress of the week in which the convention was actually held. Everything was done with dignity in Helsingfors. The open public meetings were held in the magnificent National Theatre and all other meetings, exhibits and bureaus of various kinds were in a municipal building of great beauty.

The entertainment provided was lavish and varied. It began with a special service in the Church of St. Nicholas conducted in English out of courtesy to the English-speaking delegates and ended with a banquet of six hundred covers. In the six days between, the delegates were fêted in the most delightful ways it is possible to imagine, and no stone was left unturned to make each delegate comfortable and happy. Canadian nurses will have to step lively to keep the pace thus set by Finnish nurses.

All this will take money, and lots of it, as well as an enormous amount of planning and work. No doubt the Committee on Arrangements will soon notify the Executive Committee of their financial requirements.

It is too soon yet to say what may be required in connection with the proposed survey of nursing in Canada. The joint study committee of the Canadian Medical Association and Canadian Nurses Association is busily engaged formulating plans.

This New Year will require all the members of the Canadian Nurses Association to be on tip-toe, ready to serve their organization and profession in any and every way that seems to be necessary. And so,—"A Happy New Year to all."

Infant Welfare

It seems particularly fitting at this season of the year, while our thoughts still linger upon the joys of Christmastide and our hearts still glow with efforts to promote the happiness of children, to think of the problem of infant mortality: a problem that the celebration of the Nativity of the Infant Saviour keeps fresh in our memory.

For a long time nurses in all branches have realized the gravity

of the situation and have done their utmost to provide skilled nursing care for mothers and babies in the hospital and in the home. While the efforts of infant welfare workers have reduced the number of infant deaths due to lack of hygienic care, vital statistics still bear mute evidence that an appalling loss of infant life occurs within the first few weeks of birth, and a loss of maternal life from preventable causes that points to an urgent need of measures to protect maternal, foetal and neonatal health.

What more can we do as nurses to prevent this loss of human life, in addition to the nursing service required in pre-natal and infant care?

We can acquaint our student nurses with the problem. We can assist medical associations in their study of the question perhaps better than any other organization, and we can continue to mould public opinion to a realization of maternal and infant welfare requirements.

If the question is brought up for study before women's organizations in every community, included in every health and home nursing class, and emphasized on every possible occasion as a most serious public health problem, in time every citizen in Canada would become conscious of the situation. This awakened interest would not only make easier of application those measures already known to medicine but would place within reach further means for gaining knowledge through scientific research, which would result in decreased annual wastage of mothers' and babies' lives.

Miss Nina D. Gage

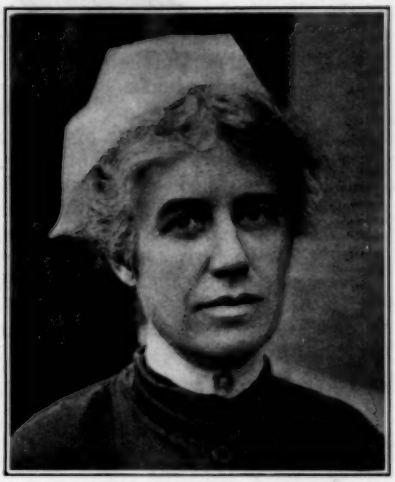
Miss Nina D. Gage, president of the International Council of Nurses since 1925, has been associated with nursing in China since 1908. Miss Gage was born and brought up in New York. In 1905 she graduated from Wellesley College and entered the School of Nursing, Roosevelt Hospital, New York, which was then under the direction of Miss Mary A. Samuel, who now resides in Montreal, and is assisting with the School for Graduate Nurses, McGill University, as a part-time instructor. Miss Gage reached Shanghai late in December, 1908. With the thoroughness which has characterized her entire professional life she studied the Chinese language for six hours each day for the next two years, except during an illness from typhoid fever and an enforced stay in Japan of a few months owing to rice riots in Changsha. In 1912 Miss Gage was able to begin her work in earnest, and the double nursing school at Changsha was formally opened in December, 1913.

During these years she helped to organize the Nurses' Association of China, of which body she was president for two years. As there was at that time no government which could function in licensing professional people in China, the Association undertook the registration of schools, examination of candidates, planning the curriculum for the creating of a nursing profession. In 1913 the College of Yale-in-China entered into co-operation with the government of the province of Hunan to conduct medical education. The Chinese were to provide running expenses for the nursing and medical schools and hospitals, while the college was to provide the faculty. In this way the Hunan-Yale School of Nursing was opened formally, having had before

that only a few pupils and no funds. From this time the school had its own budget.

Miss Gage returned to the United States in 1917-18, on leave, when she studied at Teachers' College, Columbia University. During the summer of 1918 Miss Gage acted as Director of Nursing, Vassar Training Camp, Vassar College, when an attempt was made to interest college women in nursing. Following her return to China Miss Gage became Dean of the Hunan-Yale School of Nursing, which was opened to college women, on a combined nursing and arts course, in 1921. In 1924-1925 she was again on leave, when she obtained her Master of Arts degree at Teachers' College.

Shortly after her return to China, following the Congress of the International Council of Nurses in 1925, all the schools in the province of Hunan, of any sort, were broken up, owing to the too active Bolshevik influences in Changsha. By February, 1927, hospital and school work had become impossible, and as the foreigners found they were becoming a liability rather than an asset to their Chinese friends they left. Miss Gage became Educational Director of the Willard Parker Hospital, New York City, in April, 1927.



MISS NINA D. GAGE

The Provincial Programme for Infant Care

By Miss ANNA E. WELLS, Assistant Director of Public Health Nursing Branch of the Manitoba Provincial Board of Health.

It was my very great privilege to address a conference of the Canadian Council on Child Welfare about five years ago on the subject, "Attacking Maternal and Infant Mortality in Rural Areas." You may perhaps wonder why I have the temerity to present to you once more what may seem the same subject in another guise.

However, in the past five years much progress has been made in the study of the problem, which has changed our attitude somewhat to the whole question. We are now not only interested in the question of decreasing the unnecessary toll of mothers' and babies' lives (as a humanitarian measure and consequently a philanthropic service in the past), but also in the question as it affects the whole field of public welfare, directly and indirectly.

There are critics who are afraid that infant welfare work may intensify the problem of over-population. But we are not worried over that problem in rural areas; for **there** our immigration policy is to fill up the vast vacant spaces in our country as quickly as possible. In this connec-

(Read before the annual meeting, 1927, of the Canadian Council on Child Welfare, and will be reprinted by the Council in pamphlet form.)

tion Dr. Seymour, of Saskatchewan, has expressed the feeling we all have, who are directly concerned with health work, "that an immigration policy suitable for the needs of a new country is a very vital factor in the development of that country; and is there any better immigration policy we can adopt than to conserve the lives of our infant population?" Again we find as a result of a survey made in Chicago in answer to criticisms that infant welfare work operates to preserve the unfit, that not only was the charge without evidence to substantiate it, but on the contrary the evidence showed that all efforts directed to the better care of infants not only actually lessened the incidence of disease and the number of deaths during the period of infancy but had a direct bearing on the physical health in later years. Such a study as this helps us to estimate to some degree in what measure we are building for the future health of our people.

Beginning with the vital statistics of the Dominion, usually the first source of inquiry, we find that we have a rural population of about 4,000,000 people, nearly half of the total population of Canada. In 1925, in the registration area, there were approximately 155,000 births; 12,155 deaths of infants under one year of age, 5,279 still births, and 872 deaths of mothers through child birth.

A glance at these figures alone seems to indicate that the causes of infant and maternal deaths, and still births, show an appalling need for more education in and greater attention to maternity and infant care, as nearly one-half of the infant deaths were due to conditions which might have been prevented by adequate pre-natal and maternity care. These totals include both urban and rural areas, and do not indicate the extent of the rural problem. Nevertheless, we have reason to believe that if accurate returns from rural areas were available the result would be surprising, especially in what are known as our New Canadian districts. In addition to these numbers there are the unknown and the uncounted mothers and babies who have died in the unorganized territories of our Dominion.

But vital statistics after all are only an index to conditions and problems, and therefore it is necessary to know first the environment and problems of the rural people, in the same way as in cities where corrective and preventive measures are so much easier to obtain because the conditions requiring them are obvious. Rural people being scattered over large areas and living far apart from one another do not have the opportunity of knowing in particular what health problems there are until frequent illnesses or an epidemic occurs, causing bereavement and financial loss. For this reason, maternal and infant welfare work has developed at a snail's pace in comparison with such work in towns and cities. However, no one knows more concerning this matter than the provincial officer of health of each province who watches closely the pulse of rural health conditions. So it is not surprising to find that in all provinces but one definite attempts have been made to serve the rural districts by provincial boards of health to the extent of their appropriations. Some have had more success than others, due perhaps to differences in climate, customs, laws and outlook of the people.

In answer to a questionnaire as to the organizations carrying a programme of maternal and infant welfare work in the rural districts of our Dominion, the following report, while incomplete, gives an idea as to the scope of activities:

Prince Edward Island has a population of 87,000 (mostly rural) and an average of 1,500 babies born in a year. There is only one organization doing any health work at all, and that is the Provincial Red Cross Society, which has a staff of three nurses. They are endeavouring to

carry on a generalized public health programme, exclusive of bedside nursing, with school work occupying most of their time.

When visiting rural districts the nurses invite the parents to bring infants and pre-school children to the school for conferences, as there is no time for home visiting. In villages the nurses get in touch with the babies through their home follow-up visits to the school children.

In the winter the nurses spend their time in two towns, where there are child welfare stations, from which instruction is frequently sent to rural mothers by mail. These child welfare stations serve all mothers, but there is no physician in attendance.

Home nursing classes under the auspices of the Women's Institutes and their child welfare committees have aroused much interest in infant welfare work. A health booth at the Provincial Exhibition serves as an aid in health education, and literature is distributed issued by the Red Cross Society and Canadian Council on Child Welfare.

In Prince Edward Island the outstanding difficulty which hinders progress in infant welfare work is lack of funds. The Provincial Government gives a grant of $2,500 a year to the Red Cross Society, which represents the amount that is being spent on public health in the island.

Nova Scotia has a population of 540,000 (at least half rural) and an average of 11,000 births each year. The Provincial Board of Health carries on a programme for infant welfare work through a staff of six public health nurses, consisting of a director and five nurses, who work in five counties. The nursing service is generalized and is financed by each county. Bedside nursing is undertaken only in emergencies and for demonstration purposes.

Health conferences for all infants are held by the nurses at various points under the auspices of local organizations during the summer months, but the mothers who live in rural districts require considerable encouragement to induce them to bring their infants. Baby contests are also held by local organizations and are well attended by rural mothers, many infants requiring attention being reached in this way. The development of children's health conferences in villages and rural districts is felt to be much needed.

Health literature is distributed by the Provincial Board of Health, which also conducts a health booth at the county fairs and on the "Agricultural Demonstration Train" which tours the province during the summer.

New Brunswick has a population of 407,000 (two-thirds rural) and an average of 10,000 births each year.

There is no actual rural infant welfare work being carried on by any organization, although it has been the endeavour of the Provincial Board of Health to arouse interest in the rural districts. This, however, has been most difficult to do as the people who should foster this movement do not seem to realize its necessity.

The Board of Health outlines a programme of infant welfare work and employs a director of nurses, but no field workers. The nursing director acts in an advisory capacity and gives supervision to four public health nurses, employed by municipalities receiving an annual grant of $100 from the Provincial Board of Health. These nurses work in towns and do generalized nursing, including bedside nursing. Three Victorian Order nurses also work in small towns.

There are five child welfare stations at the service of all mothers: two under the Provincial Board of Health and three under the Victorian Order of Nurses. Local physicians give their services irregularly and do not attend during the winter.

The nursing director receives considerable co-operation from the Women's Institutes, which is the

only means she has of getting in touch with the large body of rural women.

New Brunswick has one nursing outpost maintained by the Red Cross Society.

Quebec has a population of about 2,500,000 (about half rural), with an average of 85,000 births annually. The Provincial Board of Health has outlined a programme for infant welfare work and has a staff of twenty nurses, most of whom are engaged in cities and towns. Twenty child welfare stations operate directly under the Provincial Board of Health, and twenty are conducted in the cities and towns by local organizations which receive a grant from the Provincial Board of Health. Part time physicians serve these clinics, the same physician being also in charge of the tuberculosis dispensary, where these operate jointly.

The nature of the work consists in special clinics for well and sick babies, with subsequent home visits by the nurses, distribution of literature, personal talks, and public health lectures with slides and films. It is felt that the most practical work is that done in the homes by the nurses educating the mothers. Rural sections around these centres have access to these clinics, but the homes in rural sections cannot be visited regularly by nurses owing to their limited number and lack of financial support.

The Provincial Board of Health has now started a new policy in the organization of county health units, four of these being already in operation, with two nurses who cover the whole territory in their respective areas (both rural and urban) and give special attention to child welfare work.

The one great difficulty hindering the progress of infant welfare work in Quebec is the lack of sufficient funds.

Ontario has a population of 3,103,000 (half rural) and an average of 70,000 births each year. The Provincial Board of Health planned their programme of infant welfare work as part of a generalized programme of health service. A director and eighteen nurses were engaged to begin the work in each of the eight health districts to demonstrate its value to municipalities, after which the local authorities assumed entire responsibility for continuing the work. Infant welfare work consists of health conferences and home visiting. At the present time the nursing staff are concentrating their efforts in the districts of Northern Ontario. In outlying districts the settlers are seen once a year by systematic house-to-house visiting.

A travelling clinic has been used with success, and health conferences are held at summer fairs. A health exhibit is held each year at the National Exhibition and literature is issued by the Provincial Board of Health.

Since 1924, when the activities of the Provincial Department of Health and Education were amalgamated, all new health activities in the province must be sanctioned and supervised by the Department of Health if a grant is solicited.

The Victorian Order of Nurses and the Red Cross have agreed to this programme and co-operate with the Department of Health in their work of nursing organization and supervision.

In Ontario there are seventeen nursing outposts and thirty-nine nurses maintained by the Red Cross Society. These outposts are conducted as small hospitals with field nursing as a part of the service.

Co-operation is also maintained with the Women's Institutes, the Imperial Order of the Daughters of the Empire, and the Catholic Women's League, who are also interested in infant welfare work.

Financial difficulties prevent the inauguration of public health nursing in many centres where the need for it is fully appreciated.

Manitoba has a population of 639,000 (about half rural) and an average of 14,500 births annually. The Provincial Board of Health has also organized infant welfare work for the province (outside of the city of Winnipeg) as a part of the work of a generalized nursing service. This nursing service is supplied to municipalities on request and is financed by the municipality supplying two-thirds and the Provincial Board of Health granting one-third of the total cost, being administered by the Provincial Board of Health.

Twenty-eight nurses, including a nursing director and an assistant, are employed, of whom seventeen serve rural districts. Sixteen child welfare stations are established for the benefit of all mothers and four of these are attended by local physicians.

Bedside nursing care is given only in emergencies, for demonstration purposes and where specially arranged for as part of the service by the municipality.

In brief, the maternal and infant health service rendered is as follows: Through literature issued by the Provincial Board of Health, Federal Department of Health, and the Canadian Council on Child Welfare; health conferences and exhibits at summer fairs and Provincial Exhibition; health conferences for mothers at child welfare stations; health and home nursing classes to community groups of women and 'teen age girls; senior nurse students; Little Mothers' League classes to senior girls in elementary schools; home visiting to mothers and babies, which is considered the most important work; and supervision of maternity homes, institutions and boarding homes for children and day nurseries.

Close co-operation is maintained with Women's Institutes, United Farm Women, and other welfare organizations. Such organizations are a valued support to the public health nurse, and in like manner they find that the public health nurse (in her capacity as health adviser and social service worker) is an aid to them in carrying out health measures.

In Manitoba there are five nursing stations in outlying districts maintained by the Red Cross Society, which provide accommodation for emergency cases, with field nursing as the chief work of the nurse in charge of each district. Five nurses are employed at these stations and a physician visits them periodically to conduct clinics.

Saskatchewan has a population of 821,000 (about two-thirds rural) and the average number of births in a year is about 20,000. Infant welfare work in Saskatchewan is carried on in rural districts by a staff of three public health nurses engaged by the Provincial Board of Health to give assistance at health examination clinics and to conduct home nursing classes for women and 'teen age girls. The clinics are conducted by Home-Makers, United Farm Women, Local Council of Women, church organizations and in some instances by the Municipal Councils, in co-operation with the Provincial Board of Health. Following these clinics the local clinic committees usually arrange for a vaccination and toxid day, when children are protected against smallpox and diphtheria.

Six municipalities have engaged the services of a municipal nurse, principally for maternity work in the outlying districts. There is not a generalized nursing service in the province, but this year arrangements have been made with the Victorian Order of Nurses to demonstrate this type of nursing in a rural district to show the value of and need for such a nursing service. Health literature is issued by the Provincial Board of Health and, in addition, a health exhibit is conducted at the Provincial Exhibition.

A system of Union Hospitals is filling a long felt need in providing hospital accommodation for mothers in rural areas. One baby in every 5.5

of children born in the province is born in a hospital. Maternity grants are also given to mothers who cannot afford to obtain the service of a doctor on account of the distance, and also to help her to procure necessities for confinement.

There are eleven nursing outposts in Saskatchewan maintained by the Red Cross Society, which function as small hospitals, with sixteen nurses in attendance.

What is needed mostly in this province is education of the people as to the need for a generalized nursing service.

Alberta has a population of 607,000 (two-thirds rural) and an average of 14,500 births each year. The Provincial Board of Health has outlined the programme of infant work and has a director and staff of eight public health nurses engaged in generalized nursing. Five child welfare stations are organized to serve rural districts, with no physicians in attendance.

Through the women's organizations a series of health conferences are held during the summer months, which have been found to be one of the best means of arousing interest.

A travelling treatment clinic is also conducted by the Provincial Board of Health for the benefit of those in rural districts, consisting of a physician, dentist, and one or two nurses who work in co-operation with the local physicians. Treatments and operations are free to settlers in outlying districts, and a nominal charge is made to those who can afford to pay. This clinic has been well received by the people and is filling a great need.

Municipal hospitals, which are supported through taxation, provide accommodation for a large number of rural mothers. The main difficulty experienced is the lack of co-operation and interest in infant welfare work by municipal councils.

In Alberta there are three nursing outposts with six nurses in attendance, maintained by the Red Cross Society, and conducted as small hospitals with field service in addition.

British Columbia has a population of 568,400 (two-thirds rural) and the average number of births is about 10,000 annually. Work in infant welfare is conducted according to a programme advised by the Provincial Board of Health, through public health nurses who number twenty, and is financed by local organizations and a grant from the Provincial Board of Health. Fifteen of these nurses are engaged in generalized work in rural districts. They work in conjunction with the Women's Institutes, which have standing committees responsible for the promotion of public health and child welfare work.

There are twenty child welfare stations, which physicians attend in some districts.

The work of the nurses consists of bedside service in communities, home visits for follow-up of babies, health conferences, and home nursing classes to mothers and 'teen age girls. Literature is issued by the Provincial Board of Health, and health exhibits are held at the fall fairs.

An endeavour is being made to establish pre-school clinics for the examination of children, and to keep a record of their health from the time of their birth until they enter school, when such records become a part of the school medical inspection records. In this way it is hoped to have a complete health record of children from the time of their birth until they leave school.

There is also provision for maternity protection under the British Columbia Maternity Protection Act, which safeguards the expectant mother in industry and allows time for the breast feeding of infants during working hours. This provision while not a rural measure is a part of the provincial programme in infant care.

(To be concluded February, 1928)

Miss Sarah Edith Young

After 30 years of continuous service there passed away on December 4th, 1927, Sarah Edith Young, lady superintendent of the Training School for Nurses at the Montreal General Hospital.

Miss Young was born at Quebec in 1877, the daughter of the late G. B. S. Young and Mrs. Young, and granddaughter of the Rev. George Vernon Housman, for 30 years Rector of the Cathedral of Holy Trinity, Quebec.

She received her education at a private school prior to her entrance into the Training School of the Montreal General Hospital in 1897. After graduating at the head of her class in 1900, she did private nursing for a short time before returning to the hospital to become second assistant to Miss Livingston. Three years later she was appointed first assistant, the position becoming vacant on the resignation of Miss Flora Madeline Shaw.

MISS SARAH EDITH YOUNG

When war was declared Miss Young was one of the first to offer her services, as she was among the few nurses in Canada on the Active Militia List, but it was felt that she could not be spared from the hospital. However, in the summer of 1916 she was released and went overseas, serving first for a few months in England and later in France at No. 1 Canadian General Hospital. For her conspicuous and valuable services she was awarded the Royal Red Cross.

In 1917 she was recalled to Canada to become matron of Tuxedo Military Hospital, Winnipeg, and was appointed Principal District Matron of the Area. In the latter part of 1919 she returned to her Alma Mater owing to the illness of Miss Livingston, and on her retirement Miss Young was chosen to succeed her. The choice was a wise one for she continued the work so well and truly laid by the founder of the school, and it was Miss Young's ambition to uphold and carry on the fine traditions of nursing. She possessed in a marked degree those essential qualities of heart and mind of the ideal nurse and above all she was a good woman, whose influence was always felt by everyone who served with her. But only those who were intimately associated with her appreciated her real worth, for she was modest and retiring almost to a fault, never seeking praise for herself, but always so ready to give praise, when due, to others.

She has been taken away in the prime of her life; but that life is long which fills life's greatest end, and the memory and influence of her sweet life will not soon pass away but will live on and be an inspiration to the many who called her a friend.

"Blessed are the dead who die in the Lord."

On Monday, December 5th, a memorial service was held at the Church of St. John the Evangelist, Montreal, conducted by the Rev. W. H. Davison, assisted by the Rev. W. Lack. Six undergraduate nurses

wearing the regulation uniform of the hospital formed a bodyguard throughout the service, and hundreds of her friends packed the church to the doors. Masses of flowers banked the entire length of the screen and filled the church with their fragrance, expressive of the great love and respect in which Miss Young was held by those who knew her. In addition to immediate relatives and friends the service was attended by the entire graduate staff of the Western and Central divisions of the Montreal General Hospital and members of the intermediate and senior classes of student nurses, in uniform.

Following the service the body, accompanied by relatives and friends, was taken on the five o'clock train to Quebec. Immediately upon arrival at that city the casket was conveyed to the Cathedral of the Holy Trinity, where it remained, surrounded by numerous and beautiful floral tributes, until the following afternoon, when the impressive funeral service of the Church of England was held. Miss Young was buried with military honours in recognition of her service overseas during the Great War. While the solemn strains of the funeral march filled the cathedral the flag-draped coffin was carried outside and placed on the waiting gun carriage. The funeral cortege, comprising the band and firing party provided by the 22nd Regiment, the chief mourners and hundreds of citizens, started for Mount Hermon cemetery. En route Chopin's Funeral March and the Dead March in Saul were played by the band. Volleys were fired and the Last Post sounded at a point near the cemetery, where the band and firing party halted, while the funeral procession continued to the cemetery.

The service at the Cathedral of Holy Trinity was conducted by the Right Rev. Lennox Williams, Lord Bishop of Quebec, assisted by the Very Rev. Dean Crowfoot and Rural Dean A. R. Kelley.

Report of the Annual Meeting of the National Council of Women, 1927

The thirty-fourth annual meeting of the National Council of Women was held in Stratford, Ontario, from October 4th to 7th, inclusive. The Canadian Nurses Association was represented throughout the sessions by Miss Eunice Dyke, and on October 6th by Miss Elizabeth Smellie, representing the Canadian Nurses Association and the Victorian Order of Nurses.

The preceding annual meeting was held in Vancouver in June, 1926, when the nurses were represented by Miss M. F. Gray, Mrs. M. E. Johnston, and Miss K. W. Ellis. In November, 1926, an executive meeting was held at St. Thomas, with Miss F. M. Shaw, president, and Miss Eunice Dyke representing the Canadian Nurses Association, and Miss Bertha Hall, the Victorian Order of Nurses. An executive meeting was also held in Ottawa in March, 1927, with Miss G. Bennett representing the Canadian Nurses Association and Miss Smellie, the Victorian Order of Nurses.

The Council comprises fifty-six local councils, ten nationally organized societies, and two university alumnae associations.

The executive council is composed of the officers, the presidents of these organizations, the presidents of provincial councils and the conveners of standing and special committees.

The sub-executive is composed of the officers, presidents of provincial councils and the convener of the finance committee.

There are twenty standing and three special committees. Those in which the Canadian Nurses Association has a professional interest are: Education, Household Economics, Mental Hygiene, Professions and Employment for Women, Public Health, Maternal Care and Co-operation.

The next executive meeting will be held in Ottawa in February if Parliament is in session and the next annual meeting about June, 1928. The Vancouver convention considered and rejected a recommendation for biennial meetings.

A detailed report of the sessions and recommendations has been submitted to the executive of the Canadian Nurses Association.

From the Stratford convention the Committee on Co-operation which deals with the question of national affiliations has emerged with the following members: Mrs. Walter Lyman, Montreal (convener); Mrs. William Dennis, Halifax; Miss Annie Murray, New Glasgow; Mrs. F. Etherington, Kingston; Dean Mason, London; Mrs. J. P. Macgregor, Toronto; Miss Eunice H. Dyke, Toronto; Miss L. F. Stephens, Hamilton, and Mrs. Paul Smith, Vancouver.

A special conference of this committee with members of the executive who could remain was held after the regular sessions. This conference meant the cancellation of train and hotel reservations and in one instance great personal sacrifice. Conferences will be held in each centre represented by the committee. The results of these local conferences will be reported to Mrs. Walter Lyman, the convener, and presented by her to the next executive meeting to be held in Ottawa in February.

The attendance at this annual meeting was representative: three national vice-presidents, eight provincial presidents, conveners of six national committees and representatives of eleven affiliated societies and thirty-eight local councils. It is obvious that there is a national demand for the thing the Council is intended to accomplish—co-ordinated thought and if possible co-ordinated action locally and nationally in matters for which the widely differing groups of women have a common responsibility.

The greatest inspiration of the Stratford experience came from the officers and the founders of the Council who were present. One felt humble before their loyalty to the Council and to each other and before the courage with which the majority are acknowledging failure to meet the original trust and are setting themselves to the task of reconstruction. The National Council of Women was established in a simpler day when the only problem was to provide a meeting ground for isolated groups of women, few of which groups were limited to those with professional training. Today Canada has many local and national organizations divided by special interests and tasks.

The Committee on Co-operation of the Council is expected to discover means which will realize the ideal. The present committee realizes that the answer will probably be found by their successors some years hence. The executive and the committee are in agreement that conference between diverse groups nationally will result from the habit of conference established in local councils, and that the effective relationship of the conveners of national committees to the committees of each local council is essential to the development of the local council. This appears to be the best approach to the situation. The difficult questions of national affiliation must be dealt with, but in my judgment the time for that has not come. Thoughtful sharing in the Local Council of Women by the individual nurse or the local association of nurses and on national committees by representatives named by the Canadian Nurses Association may go far toward solving the question of national affiliations.

EUNICE H. DYKE.

Department of Nursing Education

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Selection of Students for Schools of Nursing

By MARIAN DURELL, Superintendent of Nurses, City Hospital, New York.

In the educational world, particularly in colleges, there is much discussion about stiffening entrance requirements, and the selective procedure most effective in choosing students from among the increasing number of applicants. We in the nursing schools do not share in this problem to the extent we desire. For we may as well acknowledge frankly that with us the predominating question has been the recruiting, not the selecting, of students. The great majority of nursing school superintendents find themselves in a position humiliatingly analogous to that of the cook who, wishing to make a super-excellent rabbit stew, read in the cook-book, "First catch your rabbit." So most of us, however ardently imbued with the desire to train a fine type of nurse, find that our big problem is first to catch our nurse.

Yet, within limits, there is a certain amount of selecting to be done in every school. We must distinguish between the eligible and the ineligible, the obviously unfit must be rejected, and, later on, those who fail to meet our standards must be eliminated.

The methods employed show remarkable uniformity throughout the nursing world, and involve the use of application blank, personal letter, health certificate, character references, educational credentials and, whenever possible, an interview. The procedure also is one that has the sanction of time. In looking over the files of our school kept when Miss Louise Darche and Miss Diana Kimber were in charge, I was interested to note how similar the methods of thirty and forty years ago were to those still in vogue.

There was the application blank, the letter stating that the applicant wished to take training because she "had been told she was a born nurse," the letter from the minister recommending her to the vocation because she was "a child of God," the statement from the family physician and the examination paper to show adequate preliminary education. The personal interview was also widely used, a fact evidenced by the succinct comment on the envelope of one applicant, "Not a lady," and on another, "Would be more ornamental than useful;" at least two nursing careers were ended within a month because one was "Not submissive in manner" and the other "Too familiar with young doctors."

Even though there has been comparatively little change in our general method of selecting nurses, there is considerable variation in the way we make use of the information we obtain. The application blank brings the important data about our applicant: Age, education, home conditions, etc. It may also bring information not so obvious, for each superintendent, without desiring to be unduly suspicious, learns that she must read with a wary eye, and search between the lines for facts that the applicant has omitted, inadvertently or otherwise. The school

(Read at the Interim Conference, International Council of Nurses, 1927.)

then decides whether it wishes the applicant to proceed further with her application. And here every school differs: the amount of education is the deciding factor for many. In other respects their ideas also vary. Most schools set eighteen as the minimum age, others believe that entirely too young; some think an applicant over thirty will be too unadaptable, others believing older women give stability to a thoughtless group of youngsters; some have certain limits of height and weight; some consider religion and race; some give generous credit to students who have been in other schools, some give little or none, others refuse them absolutely; some take no married or divorced women; and so on indefinitely.

Most schools are satisfied with the type of blank that gives such facts as these, but there is some evidence that a desire to know still more about a prospective student's personality is creeping in. At least one school, the University of Michigan Hospital School of Nursing, using the blank required of all freshmen, makes searching inquiry into the student's past activities, and her own estimate of herself in such qualities as originality, industry, popularity and leadership in the endeavour to get as complete a picture as possible.

The letter written by the applicant giving the reasons for her desire to enter the nursing profession does, of course, reveal something of this personality; culture and background may be revealed in the stationery—and in the handwriting, one might have added a few years ago. Use of English and power of expression are also evident. But it is difficult to know just how much dependence can be placed on the statements of the motives which impel them to enter, and to what extent future behaviour can be predicted. "They all have noble aspirations!" wails one principal. "How can I tell whether they will translate them into action?" Another says she finds the letters more puzzling than helpful. "If the writer is fluent in her expression of longing to help others, is she the gushing type, or is she opening her heart to one she feels in sympathy with her ideals? If she passes lightly over her reasons for applying, does she lack the proper motives, or has she a natural reticence about telling her ambitions to a stranger?"

Of far more value is the personal interview. Most superintendents ask their applicants to come to see them, if only with the negative idea of making sure that there is nothing radically wrong. If the student lives too far away, she endeavours to cover the situation by asking for a photograph. The more she is able to pick and choose applicants, the more she insists upon an interview, making it the most important factor in the selection of qualified applicants. She may ask applicants to make even a night's journey to the school, or if the trip is out of the question, arrange for her to see one of their graduates whose judgment they trust. One or two urge the mother to accompany her daughter, so that they may get a clearer idea of the home relations. In these interviews the superintendent has a chance to size up the applicant, note her general appearance, taste in dress, tidiness, and learn, if she wishes, of her interests and activities in the past. The amount of information gleaned from this personal talk depends largely on the skill of the interviewer. Perhaps if we made more of a study of the science of interviewing we might gain more knowledge about her character. We might even adopt from the business world methods mentioned by one writer: She tells of one employment manager who, in order to estimate the thoughtfulness of an applicant, seats himself with the sun shining in his eyes, so that he can see whether the applicant will notice his discomfort and pull down the shade. An-

other method which would give us equally valuable information, if we had the courage coupled with the necessary ability to try it, is that of the man who finds occasion to swear at an applicant in order to test the strain put on his temper.

The health certificate now used shows a decided change from the earlier days. Too many schools have had unfortunate experiences resulting from accepting the statement of a physician that the pupil is "in fit physical condition to enter training." Most schools do not now accept one of these general statements but require the use of blanks giving specific details, particularly in regard to tonsils and feet, and they are coming more and more to ask about heredity in tuberculosis, epilepsy and nervous disorders. Some find it a good policy to include in the forms sent out for the use of the home physician, space for use of the hospital physician after the student has entered, thus jogging his conscience with a hint, none too gentle, that his work is to be checked up later. Even if such a warning is not given, it is now routine with all the better schools to have the student examined again soon after entrance. One requires the student to come to the school for this examination before she is accepted, and a few are beginning to ask for Schick and Dick tests previous to entrance. A certificate of vaccination is also required and a statement from the dentist. In a very few cases this is followed up by a dental examination in the school. Some schools also ask a statement from an oculist.

Formerly character testimonials, like health certificates, were a matter for scoffing. Many were perfunctory, some actually misleading.

It is frequently a matter of ironic comment that the references on which the least reliance can be placed come from clergymen, whose sympathy with an individual sometimes blinds them to the welfare of a profession. Some schools are now making a determined effort to get references that mean more than those of the family friend, and not a few have come separately to the conclusion that the frankest and most dependable estimate of character is apt to come from a former teacher, or in lieu of that, from a former employer.

It is in educational prerequisites that schools show the greatest variation. Requirements differ from the standard most commonly accepted, one year of high school, to the two years of college asked by the Yale School of Nursing. Usually the school lives pretty faithfully to its standard for admission. One fact is surprising when we consider that we are dealing with educational institutions; that is the small number of schools that know, or apparently care, what grades their students have received in their previous school work. The school makes sure that the student has met the requirements of the State Board, or their own requirement if that is higher than the board's; but whether she has met it with high marks or low, it may never learn if the application for credits has not passed through its hands. Still less frequently are copies kept of the grades if the school does receive them. Possibly this is partly because the school has not sufficient clerical force to undertake more record keeping than is absolutely essential. Undoubtedly it is also due to the fact that the school that labours under the pressure of furnishing sufficient nursing care of its patients feels that it cannot care too deeply about education. One superintendent stated the situation most of us are in when she said, "If the needs of the hospital necessitate my taking in more nurses, I shall have to let down on the educational requirements since I cannot and will not lower the standards of health and moral character."

It is a pleasure to be able to record that there are a few schools so sit-

uated that they can take the pride in scholarship we would all like to take. One school advises applicants whose grades have been only around the passing mark to apply elsewhere. Another makes selection largely on scholarship. Still another ascertains in what third of her class at high school the applicant has stood, and rejects those in the lower third, thereby automatically eliminating the poorest students.

Just how much selecting schools of nursing have the opportunity of doing is difficult to judge, for there is a very great distinction, though it is not always kept clearly in mind, between the number of applicants and the number of qualified applicants. One school says it accepts about half of its applicants, others taking in classes of from twenty to seventy, say that on account of lack of room, they refuse five or ten they would really like to accept. The vast majority could and would take in more than apply.

It is interesting to note the methods of selection used in other fields where the opportunity for choice is wider. Dean Walters, of Swarthmore, in an excellent article in the April, 1927, "Scribners" describes the process in colleges. He cites one college as accepting 150 out of 1,000 candidates, and another 600 out of 2,000. No wonder that such colleges have had to create the office of Director of Admissions to handle the problem. They make their selection on the basis usually of education record (either college board examination, or school certification), testimonials as to character and promise, and health record. In matters of both scholarship and character colleges make a far more searching investigation than we do. Naturally the greatest consideration is given to the applicant with high grades, but the college is coming to place almost equal emphasis on the student who is gifted in other ways. With ideals suggested by the type of student required for Rhodes' scholars, they ask about an applicant's school activities, the clubs, teams and societies to which he belonged, his force of character and p h y s i c a l vigour; powers of leadership; how he tackles new tasks; what his attitude was towards his school duties; whether he was thinking of his rights and reaching out after them, or whether he was thinking of his duties and what he owed the school.

Along with these methods of selection, the colleges are making wide use of psychological tests. Last year 8,000 applicants took the Scholastic Aptitude Test now required by the college board, Columbia has been giving the Thorndike Test since 1918, and is so convinced of its value that it permits a student to substitute the intelligence examination for the entrance examination. Teachers' College of Columbia University has, for some time, used intelligence tests as a pre-requisite to work for an M.A. and is to use it in determining which students are of Ph.D. calibre. Many other colleges use the same or similar forms of tests and find the results worth while. They regard the test as a supplementary aid in judging a student's capacity, and realize that "there are many factors other than intelligence which determine a student's standing." Yet, in the main, they, like the Dean of Columbia, have found that "with remarkably few exceptions the higher a student's score in the psychological examination, the better his record in college."

We are all by this time of course familiar with the way the use of the intelligence test has spread since its inception a third of a century ago, and know how they are employed in elementary schools for the classification of both normal and abnormal children, in high schools, in the study of social problems, in vocational guidance, and in business for selecting new workers and classifying, readjusting and promoting those already employed. (The name, if not the content, of the tests most

commonly used are known to us: The Binet, Stanford Binet, Thurstone, Otis, National Intelligence, Army Alpha. It seems to us a self-evident fact that such tests can and do measure intelligence.) But we are slow to place too much faith in tests that measure only one out of so many factors vital to success. We have too often seen high intelligence handicapped by laziness, outdistanced by lower intelligence supplemented by zeal, or even dogged determination. (In this practical world we feel the result is often like that noted by the visitor to a school who, hearing a racket in the yard, asked one of the children what the trouble was. "Aw," said the youngster, "the doctor's just been examinin' us, and one of the deficient boys is knockin' the stuffin's out of a kid that's perfect.")

The psychologists themselves have been among the first to realize the limitations of the intelligence tests, and have made progress in working out tests to measure the other traits that make up personality. Aptitude tests have been tried, and such qualities as spread accuracy, manual dexterity, and mental alertness can be estimated satisfactorily. Various examinations have been devised to measure the fitness of applicants for a large number of vocations, as music, telegraphy, tool making, stenography. Of particular interest are the tests used for aviators where tests are made not only for intelligence but quick adjustment, motional stability, effect of altitude, muscular exertion and fatigue. Character tests have not been developed so extensively, but these too the scientists are experimenting with, and such results as the tests for trustworthiness of Dr. Voelker, and the work of Dr. Downey in testing "volitional, temperamental, emotional and character traits" give at least a glimpse of the possibilities that lie in research along this line. The psychologists who tell us that "an individual must be considered from all points of view: the economic, social, physical, physiological and psychological" have made a beginning in discovering means to make these estimates. There is much food for thought in the answer made by the little boy from Boston when asked how old he was. "That is a difficult question," he said. "The latest personal survey available shows my psychological age to be 12, my moral age 4, my anatomical age 7, and my physiological age 6. I suppose, however, that you refer to my chronological age, which is 8. That is so old-fashioned that I seldom think of it any more."

And the nursing schools: what use are they making of these newer methods, either in selecting students or in endeavouring to make accurate estimate of their abilities after they enter? Very little, it must be acknowledged. Probably psychological tests are not used to any great extent in more than fifteen or twenty, many of which are university schools. The Robert Long Hospital of the University of Indiana was one of the first to use them, beginning work in that line in 1919 in connection with the Psychological Department of the University of Indiana, and has found good correlations between their results and the theoretical work of the students: better than with the practical work. The nursing schools, like the colleges, regard their tests as merely supplementary and do not yet accept or refuse students on their evidence. (The test most commonly used is the Thurstone IV. The Army Alpha, 7 to 9, is also used to some extent.) It will be noted that so far only intelligence tests have been in use, not aptitude nor character tests.

If many superintendents of nurses have held aloof from psychological tests, it has not been because they do not recognise their value and possibilities. The present methods of selection do not give such dependable and uniform results that we will be

content to retain them indefinitely. But most superintendents have heeded this warning, that the task of testing is one for trained psychologists, and if they have no opportunity of getting such aid, they have had the judgment not to attempt the tests. True, they might seek this aid if they felt deeply enough convinced of their value. That time may not come till the testing of traits other than intelligence has been fully developed. With or without justification, we believe that nursing requires an unusual combination of intelligence, aptitude and character, and we do not feel so deep an interest in tests which reveal only one phase. It may be long before the necessary tests are developed, for if one of the fundamentals of a test is to know the requirements of the job, the making of nursing tests must be preceded by job analysis, and nursing has not now at its command the necessary funds and corps of workers for such research.

But little progress will be made if we wait for the ideal. Probably we could, if we would, make far more use of the tests even in the present stage of development. For one thing we could save time in gauging the natural intelligence of our students. All that the intelligence test can do, a teacher can do, it is said, but the test does it in five hours instead of five months. Columbia finds that the test distinguishes the dull from the reticent, the showy from the able, and that knowing the ablest men in a group they may be able to "sow seeds which they hope will result in a crop of scholars," and knowing the weakest, may be able to sympathise with their difficulties and appreciate their efforts. Miss Alice Lake, in her work with psychological tests, says: "We found them most helpful 90 per cent. of the time, especially when the student was weak and we had to make allowances. If one was weak on 'following directions' we took special precautions that she understood them thoroughly before we entrusted her with serious responsibility." So a student might be spared that working beyond her capabilities which so often leads to failure and discouragement. If tests help us to keep our patience with the less highly endowed, might they not also teach us to lose patience more quickly with the individual who is naturally gifted but nevertheless satisfied with "just getting by"?

Possibly we may find in intelligence tests the solution of this problem of the applicant of ability who is not able to obtain her educational credentials. Teachers College is admitting such students with certain restrictions, after they have passed the test satisfactorily. And it is not too much to hope that some day we will be using tests, perhaps like these for distinguishing between the extrovert and introvert, to show in what branch of nursing the graduate could most advantageously enter.

One is glad to note that psychologists with all their effort to put means of estimating character and selecting applicants on a purely scientific basis, and to substitute objective for the present subjective methods, do not fail to take into account that passionate love of one's work which we are always seeking in our applicants. "Often when the applicant is particularly insistent upon a trial at a certain kind of work or training," they say, "it is advisable to give her an opportunity even though her performance in tests is poor, because the presence of a genuine and driving ambition will sometimes take an individual over the most difficult obstacles." We, too, appreciate the rare value of this trait, and count our schools fortunate if, when selecting those applicants who will so soon become our coworkers, we find them imbued with the devotion for nursing which is the dominant force of our profession.

Department of Private Duty Nursing

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Breast Feeding

By GORDON CHOWN, B.A., M.D.,
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Holt, in his text book, states that fully four-fifths of the deaths in infants under one year, are in infants artificially fed. Put in other words, the breast-fed infant has six times as many chances of living as the bottle fed. At this time when so much is being written and so much being done in the way of Child Health organizations, Nutritional Clinics, Prenatal Clinics, etc., to raise the child to a healthy manhood, it seems to me that if we are to give him a proper start in the world, with every prospect of growing and developing into a healthy manhood that a greater effort on the part of physicians, nurses and social workers should be made to encourage and insist on breast feeding. First let it be realized that breast feeding is the normal physiological function, and I feel that with proper encouragement and advice on the part of the obstetrician and nurse during the prenatal care and at the time of confinement, that at least 95 per cent. of women could nurse their babies and nurse them successfully. While this would mean less work for the pediatrician, it would mean more and better babies for the community.

To arrive at some conclusion as to the length of time the average woman of Winnipeg nurses her baby, I examined 100 case sheets from my records, and I find the following facts:—

Never nursed	11
Nursed under 1 month	11
Nursed 1-2 months	18
Nursed 3-4 months	20
Nursed 5-6 months	11
Nursed 7-8 months	19
Nursed 9-10 months	12
Nursed 11-12 months	7
Over 12 months	1

As these case sheets were taken from every class in the City of Winnipeg, I think it is fairly safe to conclude that they are representative of the state of maternal nursing in the city. The most significant of them is that 11 per cent. do not nurse their babies at all, and another 11 per cent. nurse their babies for less than one month. I think it fair to assume that the 11 per cent. who nurse less than one month may be grouped with the 11 per cent. who never nursed their babies, bringing the total up to 22 per cent.

It is a fact that during the war in France and Belgium maternal nursing greatly increased; hence, under the stress of great economic necessity mothers have found their breasts adequate to the demands; in many regions of Japan, artificial feeding has been almost unknown; Esquimaux are said to nurse their children until the third year of life.

It is my custom in taking a history to ascertain in each instance the reason for stopping nursing, and in looking over my records, the following causes present themselves. I will enumerate the causes as stated by the mothers themselves and at the same time outline their treatment.

1. **Inverted Nipples:** This is the cause in primiparae in not a few instances, and the fact is not usually discovered until after the confinement. I would suggest to the obstetrician that the pre-natal care, more especially of the primiparae, is not complete without an examination of

(This paper forms the basis of a lecture in the course of Pediatrics for the nurses of the Children's Hospital and General Hospital, Winnipeg.)

the breasts. If the nipples be inverted, advise the gentle traction daily and massage until the nipples are well out. If this is not noted before the confinement and massage fails, the nipple shield may possibly solve the problem. The shield or breast pump should be used to withdraw the nipple into the cylindrical glass portion and then removed and the baby quickly applied to the nipple.

2. **Milk did not come in:** Jacobi, Sedgwick, Griffith, Schwartz and many other competent observers, assure us that agalactia or physiological failure of lactation is practically unknown. It may be necessary to point out that the appearance of breast milk is occasionally delayed until as late as the tenth day, and one should not be too ready to assume that there is no milk and institute bottle feedings, because by doing so, you remove the greatest stimulation to breast milk secretion, viz., the regular and repeated demand on the breast. I think if the breast milk is not established by the end of the fourth day, that one is justified in putting the infant on a formula, but in no instance should the formula given equal the caloric requirements of the infant, and in every instance it should be given as a complementary feeding. By this I mean at regular three-hour intervals the child should be put to each breast, and following the nursing, it may have its feeding. In this way in a great majority of cases, free secretion of breast milk can be established in a few days and the complementary feedings done away with.

3. **My physician and very frequently the nurse had the milk examined and informed me it was little better than water:** Too often breast milk is rejected as of too poor quality on the meagre evidence furnished by the examination of a single small specimen. On enquiry how the specimen was obtained, in every instance it is the foremilk that has been pumped off by the mother and sent to the laboratory. The foremilk is always low in fat and total solids, just as the hind milk is rich in these two respects, and if one wishes to obtain some idea as to the average percentage composition of the milk, he should be careful to obtain the mid-milk. But even when this is done, breast milk differs so much in quality and quantity at different periods of the day and at different periods of the nursing that for any correct conclusion to be drawn from a chemical examination of breast milk a 24-hour sample should be collected. And were this done, I do not hesitate to say that such an examination will rarely reveal any variance from the normal. My authority for this statement is an exhaustive study of human milk by Talbot of Boston. (Reiss, Breastfeeding, Archives of Pediatrics, May, 1921.)

4. **I had not sufficient milk—baby was not satisfied:** Too often the mother's statement to this effect is accepted without the necessary conclusive evidence gained by weighing the baby before and after each nursing, for a period of 24 hours. This, I may say, is the only accurate way of giving support to the mother's statement. Should the statement be substantiated, the treatment should be complemental feedings, and not supplemental feedings, because there is no disputing the fact that breast milk in no matter how small a quantity aids in the digestion of cow's milk. Manual expression of the breast following the nursing will increase the amount of breast milk.

As an illustration of Nos. 3 and 4 I wish to quote a case:—

Baby girl, age 2 months: present weight 8 pounds. Mother primipara; full time; birth weight 8 pounds. The physician in charge of this case at the age of one month, as the baby was not doing well, and was restless, had the breast milk examined and the report returned showed fat 1 per cent., protein 1 per cent. With these facts before him, he advised nursing three times and supplementary feed-

ings three times. At the age of two months, as the baby had not gained in weight, I was consulted. Physical examination of the baby was negative except for undernourishment. Examination of the mother's breast by expression revealed a fair supply of breast milk. I advised nursing each breast every three hours—seven feedings in 24 hours, and in the course of 24 hours learned the amount of breast milk secreted by weighing before and after nursing, and ordered complemental feedings of skimmed milk and water to be given after each nursing. Within two weeks, with the regular stimulation and emptying of the breasts the mother had sufficient nurse for her baby; and within six weeks was able to supply two nursings a day to an artificially fed baby in the suite below who was not doing well.

5. **Baby fretful and colicky, would not sleep, and was having 6-7 green stools a day with curds:** These are the types of cases where one can almost always say at once, that it is a case of overfeeding. I think I cannot do better in illustrating this type of case than by referring to another case:—Baby F., age 6 weeks: birth weight 5½ pounds, complaint—colic, frequent green, loose stools, a stool after every nursing. Physical examination of the baby negative. The interesting feature was that in spite of this colic, 9-10 green stools in a day with curds, he had gained two pounds in weight. Mother had large breasts, tense and full at nursing time, and on account of his restlessness she was feeding him every 2½ hours, 9 feedings in the 24 hours. To increase her supply of milk, in addition to three substantial meals a day, she was taking 1½ quarts of gruel and milk, stout, galactogol, and leading a sedentary life. My treatment here was to stop all extra food, to nurse her baby every three hours, 7 feedings in the 24 hours, for no longer than 15 minutes, and walk a mile or two each day. Within ten days, the stools had become two a day, normal in character, and the baby continued to nurse for eight months. The present day tendency especially with nurses is to examine the stool closely and if a few fat curds are seen to assume that the baby has an indigestion. The nurse expresses this fact to the mother, causing her needless anxiety and worry which is the chief cause of colic in infants. Practically every breast milk stool shows fat curds. If the baby is thriving my advice is always to look at the baby and not at the stool.

For colic and frequent stools one ounce of water before the nursing and lengthening the period from three to four hours is of decided benefit.

6. **The mother temperamentally unfitted to nurse her baby:** This possibly forms the largest class that do not nurse. Holt says, "that it is the nervous temperament of the mother which largely decides her success or failure as a nurse. If the mother would nurse successfully, she must have plenty of rest and sleep, moderate exercise, keep her mind free from unnecessary worries, avoid social engagements and lead a simple, natural life. Unless she can and will do this, successful nursing can hardly be expected."

Here again, let me say that the obstetrician in his pre-natal care of a mother, should do all in his power to see that she is physically and psychologically ready to carry out the nursing function. Much can be done by explaining to expectant mothers that four-fifths of the babies that die before one year of age are artificially fed babies. Also, that by virtue of nursing, their babies receive considerable immunity to any disease which they may have had during their life.

It may be necessary to exaggerate, but I consider that any amount of exaggeration is justifiable in order to obtain this end.

The question now arises, as to what may be considered the absolute

contra-indications as to maternal nursing. In this connection I was interested to see in the excerpts from foreign publications as printed in the Journal of the American Medical Association, dated July 9th, 1921, a report by Molden Hauer, who made a study of 30 lactating women with various diseases, to determine the effect on infants of nursing by a sick mother. His report may be briefly summarized as follows:—

In open tuberculosis and true dysentery, it is wise to forbid nursing on account of the danger of infection to the infant. He quotes six cases of mastitis, even though the breast was incised and suppurating freely, nursing was continued, as well as four cases of aseptic operations for hernia, interval appendix, cholecystectomy, and five other operations for septic causes, also five cases of multiple sclerosis, bulbar paralysis, or neuropathy with a tendency to suicide, ten cases of various internal infectious diseases. In all of these cases no harm came to the infant from nursing the sick mother. In two cases of severe dysentery, for fear of contagion, the infant had been taken from the breast; but still it proved possible to keep up the secretion with a breast pump, with a minimum of 100 gms. daily, and at the end of six weeks, with the aid of a vigorously sucking infant, the breast secretion was brought back to normal and the mother's own child returned to the breast to nurse.

I have recently had occasion to see two infants both of whose mothers had had an operation for mastoiditis. One of these infants was placed in the Children's Hospital to be returned to his mother at the end of four weeks. The other was boarded out with his sister who took care of him for ten days, and as a result these infants were summarily weaned. Had the specialist in these cases given more consideration to these infants, it would have been possible to return them to the breast at the end of twelve hours after operation and thus continued the lactation.

On the other hand, if it were considered inadvisable to return the infants to the breast, the secretion should have been maintained by regularly emptying the breasts by artificial means.

To further impress you with the value of breast milk as a life saving measure, the following may be of interest: For a number of years it has been the policy of the Babies' Hospital, New York, to send a nursery maid, trained in the art of expression, to the East Side every morning. She expresses breast milk from the mothers there, and it is a poor day that she does not return with one quart of breast milk. She pays for the breast milk at the rate of five cents an ounce. The nurses vie with each other to obtain the breast milk for their very ill babies.

There is another woman in New York who makes a business of obtaining breast milk in the same way and selling it to the wealthy at the rate of 50c an ounce.

A paper of this sort would not be complete without referring to the work of late Dr. Sedgwick of Minneapolis. Through his efforts, with the aid of a systematized propaganda, 96 per cent. of women in Minneapolis are nursing their babies at the end of the second month, and 72 per cent. are nursing at the end of the ninth month. In one thousand consecutive cases, in the New Born Clinic of the University of Minnesota in which the mother and the baby left the hospital together, each child was at the breast. As Sedgwick justly says, this does away with the bogie agalactia. He was the first to point out that it is the persistent demand on the breast which is the most important and continually neglected factor in the establishment, maintenance and reinstitution of natural or breast feeding. He considers the three regular meals are all that is necessary for a nursing mother, and that the forced feeding, as generally

adopted, plays no role either in the establishment or increasing the supply of breast milk.

How often is the same cry heard, that all the food I have been taking went to me and not to the baby; and growing fat is a sore point with most women.

If the babe does not do well at the breast, Sedgwick states that the trouble is practically always with the babe itself or with the quantity and not with the quality of the milk. I have referred on one or two occasions throughout this paper to the emptying of the breasts by artificial means. The breast pump is generally unsatisfactory and Sedgwick's method of expression is one of choice. The expression is carried out as follows:—

The breast is grasped one or two centimetres back of the colored areola, and a milking motion, using the thumb and first finger, is carried out towards the nipple. No massage of the breast proper is allowed as it is of little if any value, and sometimes causes traumatic inflammatory action. To show what can be done by this method of expression, Apt, in his paper on Wet Nurse Management, Journal of American Medical Association, dated August 11th, 1917, quotes that the average daily yield from a wet nurse was 38.5 ounces a day or 247.3 quarts in seven months.

Further details of Sedgwick's work may be found in the Journal of the American Medical Association, vol. 69, No. 6, dated August 11th, 1917, and in the American Journal of Diseases of Children, vol. 25, No. 5, dated May, 1921.

In conclusion a mother with her first baby depends almost entirely on the advice of the nurse in attendance. With reference to breast feeding, the nurse should realize that a baby fails to thrive on the breast for two reasons only, viz., there is something wrong with the baby or the breast milk is insufficient in quantity. This requires a diagnosis.

Constipation

The lack of peristalsis and inadequate action of the intestines produces stagnation in the alimentary tract, which results in infrequency or irregularity of bowel action, or constipation.

There are many different causes of constipation, some congenital, or anatomic; others mainly hygienic. A frequent cause is inattention to the formation of the habit of emptying the bowel at a regular time each day. The most favourable time is immediately after breakfast because the morning meal stimulates peristalsis in the intestinal tract. The necessity for a regular habit of defecation must be impressed on children. Attention to diet is an important factor, particularly in regard to fluid intake. Very few people drink sufficient water. The continual use of laxatives is harmful and should be discontinued. Some form of liquid paraffine, recommended by your doctor or nurse, should be taken regularly, immediately before or immediately after meals, according to directions. If this is done, a well-balanced diet adopted, and plenty of water taken, regular habits of defecation can be formed and the most stubborn cases of constipation overcome. But it must be borne in mind that internal cleanliness is secured and maintained only by the same unremitting daily care that one ungrudgingly bestows on the exterior. And it is more important.

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The Problem Child and the School Nurse

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In venturing to speak to you on the Problem Child and the School Nurse, I feel I am attempting a large order, but it is a subject we are all becoming more alive to and more keenly interested in. We are just beginning to realize its possibilities and effects. But until we settle down and really seriously think about it—to study the causes—we do not realize how immense a field it is or where it is apt to lead. We will have to reconstruct many of our established ideas and pet theories and probably change them from time to time as we learn to look at things from a different angle.

I cannot do more than touch upon a few points. Some simple everyday, common occurrences.

The first question asked in the Mental Hygiene Primer is: "What is Mental Hygiene and whom does it concern?" It goes on to point out the obvious but generally disregarded fact that the mental health of a community is as important as its physical welfare. It is obvious, because without mental health even the most vigorous of us physically c a n n o t maintain satisfactory or economic adjustments, generally disregarded because of the stigma, that result of medieval superstition, which clings so tenaciously to our mentally sick, and because we are prone to neglect things which are either unpleasant or little understood. The Mental Hygiene movement is everywhere embarrassed by a popular fallacy that it seeks only to prevent or lessen cases of actual disease. Though concerned primarily with mental disorders, it also includes other conditions equally important and far more numerous. The work is not only for those who suffer from mental disorder or defect, but for all those who, for one cause or another, are unable to so adjust themselves as to live happy and efficient lives.

When we consider that the child of today is the man of tomorrow and therefore the most important of all things that live and grow, it is surprising how little attention we give to the normal habits and traits of children. If we wish to produce a perfect flower we study the nature and need of the seed and plant, place it in the surroundings best suited to these, care for it and if the conditions are right for that particular plant the result is a blossom that is a joy to all beholding it. The flower we should try to bring to full bloom in children may be called the normal personality. In the struggle for existence later on in life this will be invaluable. It insures not only a reasonable degree of success but above all it means satisfaction and contentment with life. On the other hand if the surroundings do not supply what is required, forcing the normal traits in the wrong direction, then the result will be a stunted, ugly, abnormal personality, bringing unhappiness, possibly mental disease, and failure in adult life.

What are these traits that all children have and which must be carefully handled if full mental growth is to be reached?

First, children are imitative: speech depends largely upon imitation. When a baby begins to talk it is imitating what it hears, naturally it imitates bad examples as easily

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as wholesome ones. The moral is clear: deception, selfishness, indulgence, bad temper, cruelty and the like should not be displayed by those caring for children, for eventually the baby will copy them just as surely as it learns its first words.

The child is suggestible. This means all kinds of unhealthy thoughts and unnatural behaviour may be suggested by unwise words or actions. The mother who remarks when her little girl stumbles or drops things, "Mary is so nervous, just like her father," is certainly suggesting nervousness, and if she continues to do so the child will become handicapped for life. The moral here is never discuss with other people a child's successes or failures in his hearing.

All normal children are curious. It is fortunate for the future of civilization that they are. All the inventions that make life easy, telephone, electricity, motor cars and so on, all the things you and I do in our care of the sick, are because somebody was curious enough to experiment. Don't lose patience with the small child who asks innumerable questions, but remember that youngster is merely trying to satisfy a craving for knowledge, that he needs just as much as he needs sunshine, fresh air, milk and proper diet in order to develop his body. Children are usually more curious about sexual things than anything else. This is because they soon become aware of a conspiracy or silence about this subject, so naturally their curiosity becomes intensified. It seems wiser that innocent questions should be answered in a simple, straightforward way in accordance with children's ability to understand. This curiosity cannot be stifled and if they do not obtain satisfactory information from their parents, they will get ugly and harmful misinformation from other sources, especially once they begin school.

Children love power, they naturally like to hold the centre of the stage, for who of us doesn't enjoy a little limelight now and then? So long as this desire to attract attention doesn't go too far it may be treated more or less casually, for the child soon learns to understand it must respect the privileges of others.

Many children pass through a phase of wanting to run away and embark on adventurous careers, or they are continually romancing and telling wonderful tales, in which they always fill the role of hero. This is merely a stage in their normal development. There are many good and harmless substitutes for these proclivities. Outdoor sports of all kinds will not only provide a healthy outlet but will also increase a reserve of physical health for use in later life. Acquaintance with good literature will satisfy the imaginative fancy, and by the exercise of good judgment and gentle training the child will gradually be taught to distinguish between truth and fiction. His imagination will be permitted to develop but at the same time the principle of truthfulness will be implanted in the growing mind.

About punishment, there are just these things I want to stress: whatever the mode of correction it must fulfill certain requirements. It should be reasonable, fair and prompt. The offense must be closely associated with the punishment which is to follow. If a child gradually comes to realize that certain conduct of his invariably results in pain or in being deprived of one thing or another, he avoids that sort of thing. Punishment should never be threatened and then not administered. Children all too soon recognize a failure to keep a promise of any kind and they lose respect for those who break promises. Punishment that is merely an expression of anger creates a perfectly proper anger and rebellion on the part of a child. The person losing

his self-control is misbehaving worse than the child, and the child knows it. Such punishments may create fear in a child so that it "minds" but its good behaviour is purchased at too high a price, for the reason that hatred of, and rebellion against, authority becomes a fixed emotional habit leading to great difficulties later on. Fixed habits are always very hard to overcome though often easily acquired.

In helping a child to develop healthy mental habits it is wise to keep this in mind: permit a child as much freedom of expression as possible, allowing him to find an expression for himself and his own particular interests in his play, in his work and his contact with others. If this expression interferes with others or is unwise, direct his energy tactfully into other and better channels, but be careful not to force a repression on a child that will be harmful. Help a child to maintain his self-respect. Never by word or action take away or belittle what self-respect he has. In cultivating healthy mental habits in a child we shall usually find it well worth while to do a little cultivating in our own personal garden.

You are doubtless wondering why so much talk about children in general when I am supposed to be talking about problem children, but one must give a little consideration as to what is good for all children, in order to avoid having a problem to deal with.

A problem child doesn't necessarily mean an abnormal or a subnormal one, but one who is unable to adapt himself to carry on successfully. There are many factors that may enter into the trouble—it may be due to bad habit formation, unsuitable environment, unsympathetic or unwise handling by those in charge of the youngster, lack of co-operation between home and school. It may be due to some physical disability; it may be mental retardation or an incipient mental disorder, or it may be due to any combination of these factors.

There is no rule of thumb for dealing with the problem child: you cannot sort such children into neat little piles like you do slips for defective teeth or diseased tonsils. Each case must be dealt with on its own merits, and only after a careful study of all the underlying causes with a balancing of the assets and liabilities. If the material is poor, you can't expect a perfect result any more than you can make a silk purse from a sow's ear. We cannot all be vessels of silver or gold and the humble, well-made earthen one gives a much more efficient and faithful service in its lowly place than the silver one that has a flaw.

How may the school nurse help with problem pupils? These children may come from any grade from the kindergarten up through the senior IV or even higher, and they may come from poor or well-to-do homes. Why are they problems? In a group of 46 such children in one school, 35 were reported as having trouble in keeping up with their classmates in one or more subjects. In each case where there was a suggestion of retardation a Binet Intelligence test was given. This eliminated 16 who were found to have retardation of from three to six years, showing they were in need of special teaching. The academic troubles of the other 19 were associated with, if not the disguised expression of, such re-actions as shyness, laziness, inattention, vicious tendencies, sensitiveness to criticism, day-dreaming and hypochondriacal fears with resulting irregular attendance. The 11 remaining were referred for such difficulties as temper tantrums, sulleness, crying spells, twitching, indifference, excitability, poor co-ordination of hands and so on. So familiar are the majority of these re-actions in the everyday world that in our rather breathless hurry, we simply don't pause to consider these facts as having a great

bearing on the problem. Faulty nutrition, inadequate exercise or play, lack of proper sleeping accommodation, insufficient sleep, poor lighting and ventilation, a poorly balanced school curriculum are very important facts, but you and I want concrete facts about the shyness, the twitching or whatever the reported trouble is. To understand his inability to concentrate, his impulsive behaviour, his lack of satisfaction in his work or play, we must go carefully into that child's history. The facts must be gleaned from every available source: from the teacher, the parent, physician and from the child himself. Don't neglect the last. Digging up this information is not always so difficult as it may sound, though I frankly admit it is rather a lengthy performance. With a few exceptions, parents, once they understand you come to help, not to criticize or find fault, will talk more freely and are usually eager to understand and learn to adjust the trouble as far as possible, even if it involves some personal sacrifice, the giving up of some pet theory of training that has been considered successful with their other children. It is not all done in a twinkling of an eye, but it is your job and the teacher's to get those parents to do their part and you must also gain that child's confidence and co-operation.

In studying a problem child one of your first tasks it to make sure the child has a thorough medical examination so that any defects may be corrected and these physical handicaps eliminated as far as possible. If a child is inattentive, is it because he doesn't see or hear properly? Slight defects, in hearing especially, are often overlooked, sometimes because the child may not realize the trouble or is unwilling to acknowledge it. Sometimes it isn't recognized because our methods of testing for defective hearing at school are very imperfect and elementary. Is he inattentive or lacking in energy because his bedtime is late and irregular? Does he sleep as the centre member of three in a bed and with a hermetically sealed window? If so, it is no wonder he yawns and stretches and tires out early in the day. While you are finding out these details you have a chance to steer the conversation into a channel that brings out the information about his earlier life. What serious illnesses has the child had? Be specially careful to go into the history of any severe toxic conditions: poliomyelitis, encephalitis, meningitis, convulsions, and head injuries, as many of these things cause very definite changes in a child's personality and have also the effect of slowing up his mental development. What about his mother during her pregnancy? Were there complications? Was his birth normal or were instruments used? Was he breast fed or experimented upon with numerous weird feedings, suggested by helpful neighbours? All this will gradually lead you back to getting the history of his parents and give you a chance to see what his heredity is, what sort of stuff his parents are made of, and what their ideas of bringing up their children are. Do they frighten the children into obedience, do they talk about mysterious hobgoblins and instill all sorts of unwholesome fears in their unfortunate offspring's mind—terror of the dark, of dogs that always bite, or horrible punishments on earth or hereafter? Do they continually talk of the child's behaviour, or poor health, in his presence? Naturally children should not be present during any such discussions.

Does the mother tell him constantly about her own nervousness so she may have his sympathy, incidentally implanting ideas of the same trouble firmly in his receptive little mind? Does she worry and fuss over him, coddling him physically and mentally, thus denying him independence of thought and

action and repressing his healthy activities? Do the parents set the child a bad example by squabbling and raving, scolding or nagging each other and the children? Do they allow him to get his own way by exhibiting these same sort of temper tantrums? Do they make him dishonest by lying to him or before him, evading his questions, refusing him things he wants for no real reason, dealing out harsh treatments for minor offenses as an outlet for their own emotions? Does one parent shield him from the other, boast of some dishonest practice before him or make a hero of some one noted for dishonesty? Do they let him attend all sorts of movies and any time he wants to go? If you find parents who do these sort of things, how can they expect their children not to follow the example? In your dealing with parents, can you not bring even a slight realization of the grave injury they are doing their children? You can, at least, make them begin to think about it, and if you make them think **often enough** along this line, they will unconsciously try to overcome things, even if they at first are unwilling to pay much attention to you. There are few parents who won't make sacrifices for their children, if only for the sake of peace in the home.

Sorely tried teachers are not exempt from some of these very failings any more than the rest of us, and I find them quite prone to forget the long ears of the little pitchers and to start discussing, before the class, the special children to be examined. It is a serious mistake and may lead to great unhappiness for those very children. For quite apart from feeling themselves singled out and to be something queer, the others are only too delighted to have something to tease them about and jeer at them, for, as you know, children can be horribly cruel to each other.

Beside your talks with the grown-ups, you won't get far if you don't establish a good contact with the child, but never by conspicuously singling him out. Let your talks with him apparently be casual meetings, or chance chats; sometimes you may get him to help with some odd job or go an errand or two for you. Anything that won't make him self-conscious. Try to see things from his angle. If you can't get yourself back to how things looked to you at that age, recall how you felt when the circus came to town, your intense interest in everything connected with it: your thrills over the closed, gilt wagons, your passion for pink lemonade and peanuts. That never fails to get one back into a happy frame of mind, and helps one to see things through a child's eyes. The main thing is to find some point of common interest. If you love children—and you can't be a school or a health nurse successfully if you don't—it won't be hard. Make him forget, for a while, you are some one in authority, therefore in his present unhappy state, one to be avoided and looked upon with suspicion.

The most essential thing in studying a problem child is to have him seen by a psychiatrist accustomed to dealing with difficult children. Otherwise how are you to learn what intellectual and emotional material, and its possibilities, you are trying to deal with, but remember the psychiatrist cannot carry out his examination satisfactorily if the nurse has not collected and arranged all available information concerning the home, parents and child. The teacher's report also must be ready and this must not only show his progress, good and weak points, but must be a frank statement of the particular trouble the child presents. Why give the reason for examination as "poor progress," "seems retarded?" Anyone can glean those facts by looking at the school card, by comparing the grade with his age and attendance. For instance, we had a boy come up for examination

the other morning with a report like that, but not one line stating he was always sulky and disobedient, and had even sneaked a soft snowball into the classroom a few days before and thrown it at a boy who had poked fun at him. No mention was made of the fact he would not respond to either kindness or punishment. If the nurse and teacher don't combine to give the psychiatrist some real facts, how much time must he waste, sometimes unsuccessfully, trying to get at the trouble? He is invariably a busy man with many children to see. One other thing about a child coming to see the doctor: don't let him get the idea it is because he is to have his "brains tested," or because he is a "dumb-bell," as has happened on many unhappy occasions.

The examination does not merely consist of a Binet Intelligence test, though this is always part of the routine. It is useful in getting the child's intellectual level and an idea of his capabilities, but it does not pretend to measure emotional reactions, though often the child's answers and attitude give you a great light along these lines. I am not in the least belittling the Binet, for it is a most invaluable and necessary aid, but often people get the idea that it is all there is to a psychiatric examination. I would like to advise you here, that when using the result of the Binet test you will find it a much more useful working basis if you go by the mental age assigned the child, rather than the intelligent quotient. Many children with a comparatively low I.Q., who are steady-going, routine beings, will eventually turn into far better citizens than those with high I.Q.'s, who are unstable, highly excitable, impulsive and neurotic.

In the rural work, at present, I realize you are more often than not unable to have the advice of a psychiatrist. You cannot expect to make headway with any difficult and complicated cases, but you can at least try to get a good idea of all the factors which are unsatisfactory and adjust these to the best of your ability. Sometime the key to the situation will be thrust into your hand in some unexpected fashion.

A boy of 13 or 14 came to see the doctor last week. He wasn't getting on, didn't work, was impatient, but never actively disobedient, he was popular with the boys out of school, liked all sorts of sports and was no problem at home. The Binet test showed him to have a little more than average intellectual ability and to be quite capable of doing work in a higher grade. He was enthusiastic when talking about outdoor life, but very embarrassed and uncomfortable when school work was mentioned. He fiddled with a pencil, scuffled his feet and didn't look the doctor in the eye any longer. Finally when he thought it was all over, he stood up twiddling his cap in an undecided manner. The doctor was apparently very busy writing and didn't look up, though he was just quietly waiting for a disclosure. It came, for suddenly the boy blurted out the truth; his teacher was alright, she was kind, very fair and he liked her fine, but as he said "Gee, doctor, I'm too old to be taught by a woman. I want a man teacher who knows about games. Skirts are alright for little kids, but I'm too big now." Many times some very simple unsuspected thing, like that, lies at the root, but often the trouble is to diplomatically straighten it out. The school authority must be backed up and the child not allowed to feel he is putting anything over.

Sometimes you find a child who is failing because of a feeling of inferiority. The others both at home and school are quicker and brighter. The youngster is made to feel this by being left out of things. The others may not be conscious of this superiority, but they just don't expect much of him. Find out what

sort of thing a child like this can do well, for usually there is some compensating ability, and make the most of what he has. Maybe he is handy with tools, has a mechanical flair, and if he is made to feel that he is the one the family depends on to fix things because he does it so well, he'll be contented and develop a great sense of responsibility. A little responsibility and regular jobs at home are good for all children, but don't load the slow one with all the uninteresting and tiresome jobs: like always having to mind the baby while the others play baseball. If a boy is continually restless in school, find an outlet. It may be due to the fact the work of that grade is too easy for him and doesn't make him work. Whatever the trouble is, an outlet must be found, some way to work off his surplus steam before the safety valve blows off! Sometimes we have found certain very restless boys who have been more readily controlled by being allowed to spend the last half hour so often a week working at a bench in the auxiliary class. This being only allowed on condition of satisfactory behaviour.

If a child pays constant visits to the nurse's office on all sorts of excuses, a headache today, a fancied pain here tomorrow, a scratch next day, find out, after you are sure there is no physical basis, what is at the bottom of it. Is the little girl hearing too much about other people's pains and aches at home? Is she looking for attention because she longs for some kindness and sympathy, being denied this at home, or is there a spelling or an arithmetic lesson she wants to avoid in her classroom?

In each case you can't do any adjusting until you find out the cause, just as we had to do that same thing before we learned to handle physical troubles. Don't try to undertake a lot of cases at once. Select rather a few cases, study them carefully, building up your background: that is the history and environmental factors, keeping the problem in mind, then try to straighten out the tangle. If you keep track of what you accomplish, both successes and failures, and go back over these occasionally, you will find it well worth while.

Essay Competition

In order to stimulate an interest in and a knowledge of the causes of maternal mortality, the Council of the Saskatchewan Registered Nurses Association has arranged for a competition, open to all nurses registered in the Province of Saskatchewan. To the nurses sending in the best essays on "Causes of Maternal Mortality" prizes are offered as follows: First prize, $25.00, offered by the Local Council of Women; second prize, $15.00, given by the Saskatchewan Registered Nurses Association; third prize, $10.00, given by Dr. Lilian Chase, of Regina.

The competition is subject to the following rules:—

a. To be open to all nurses registered in Saskatchewan.

b. Essay not to exceed 3,000 words.

c. Essay to be typed on one side of paper only.

d. That these essays become the property of this Association, and may be published at the discretion of the Association.

e. Writer's name to be on separate paper, accompanying the essay and no identification marks whatever to be used.

f. To be in the hands of the Secretary of the Saskatchewan Registered Nurses Association, Elda M. Lyne, 39 Canada Life Building, Regina, not later than January 31st, 1928.

News Notes

On the morning of Armistice Day a basket of lovely brown and yellow flowers, with yellow tulle, was placed before the Memorial Panel to Canadian Nurses in the Hall of Fame, Parliament Buildings, Ottawa. Miss Gertrude Garvin of Ottawa writes: "It is surprising how much interest centres around this beautiful memorial. I never go up but I find many people there. The guides interpret its meaning so beautifully, too." The members of the Canadian Nurses Association are indebted to Miss Garvin who has seen that in the name of Canadian nurses flowers have been placed before the Panel on each Armistice Day. This is a custom which it is hoped may be continued throughout future years.

ALBERTA

The conjoint convention of 1927 of the Alberta Association of Registered Nurses, the Alberta Hospitals Association, and the Alberta Municipal Hospitals Association, was held in Edmonton on November 21st and 22nd in the Memorial Hall, Edmonton.

The business session of the A.A.R.N. was held during the first morning, while the afternoon was given over to meetings of the three sections, unfinished business and a talk on The Canadian Nurse magazine by Miss Jean S. Wilson, executive secretary C.N.A.

All in attendance met at a public meeting in the evening when addresses were given by Dr. M. R. Bow, deputy minister of health for Alberta; Miss Jean S. Wilson, who spoke on the work of the Canadian Nurses Association, and Dr. M. T. MacEachren, director of hospitals for the American College of Surgeons. Dr. MacEachren gave an interesting illustrated lecture on the hospitals of Australia and New Zealand.

An outstanding feature of the convention was that the programme had been arranged that papers were given dealing with many problems in the hospital and nursing services. These papers were to the point, but brief, allowing sufficient time for all round tables, presided over most ably by Dr. M. T. MacEachren. Considerable discussion followed the introduction of the question of schools for nurses including training in special hospitals for tuberculosis and mental cases.

One of the principal matters dealt with by the A.A.R.N. was the adoption of the following resolution which effects a change in the award of the annual scholarship:

"That the conditions under which the scholarship was awarded up to 1927 be rescinded.

"That hereafter the scholarship be increased to five hundred ($500.00) dollars and awarded biennially as at present.

"That the scholarship be awarded on application to the executive council.

"That the award be open to all nurses trained and registered in the Province of Alberta.

"That the applicant be asked to submit to the council, statements of academic training, professional training, and experience since graduation—together with information regarding post-graduate work contemplated.

"That all applications for the scholarship should be in the hands of the secretary of the Association not later than May 31st, of the year of the award, and that the award be taken advantage of within six months of the date of the award.

"That in the event of inability to make use of the scholarship after the award has been made, applications shall be reconsidered and a new award made.

"That the next award be made in the year 1929."

And further:

"That in the event of the 1924 and 1925 scholarship not being made use of, the first award under the foregoing conditions be made in the year 1928."

Under the leadership of Dr. T. H. Whitelaw, medical health officer of Edmonton, the Alberta Health Officers' Association was organized for the first time.

The exhibit of hospital equipment and supplies was splendidly arranged while special mention should be made of the exhibits prepared by the Travelling Clinic of Alberta, the Central Alberta Sanatorium, the Junior Red Cross of Alberta, the Edmonton Branch of the Victorian Order of Nurses, the Provincial Department of Public Health, and the Royal Alexandra Hospital, of Edmonton.

On Monday the delegates and visitors were guests of the local associations at a luncheon, and on Tuesday the Edmonton Board of Trade entertained the entire convention at lunch, followed by an illustrated talk on hospitals by Dr. MacEachren.

Dr. Baker, superintendent of the Central Alberta Sanatorium, was elected president of the Alberta Hospitals Association, to succeed Dr. H. Smith, superintendent of the Royal Alexandra Hospital, Edmonton.

The members of the A.A.R.N. were most grateful for the deep interest which Dr. Smith showed towards nursing during his term of office and feel assured that the same interest will be maintained in the future.

Miss S. Macdonald, superintendent of nurses, Calgary General Hospital, and first vice-president of the A.A.R.N., presided over the A.A.R.N. sessions. Miss Macdonald was elected president for the year 1927-28.

CALGARY

Miss Jean Wilson, executive secretary of the Canadian Nurses Association, spent a few hours in Calgary en route from Edmonton to Winnipeg on Wednesday, November 23rd. The Calgary Association of Graduate Nurses entertained her at a luncheon in the Hudson's Bay and in the evening Miss Wilson addressed a large number of the graduate nurses in the lecture room, Holy Cross Hospital. Miss Wilson gave the nurses an intimate description, in an informal way, of the national organization of nurses, which was later followed by discussion Her address was most helpful and interesting to all present. The nurses much appreciated the privilege of meeting Miss Wilson.

Miss Bessie Donaldson, Calgary General Hospital, 1924, who has been doing special nursing in Chicago and New York for the past two years, is visiting friends in the city.

Miss Mary McRabbie, Holy Cross Hospital, 1925, died very suddenly after three days' illness at the Cardston Hospital, November 8th. Her untimely death at the early age of twenty-four was a great shock to her many relatives and friends. The funeral services, conducted by the Rev. Rex Brown, were held on November 11th. Miss McRabbie is survived by her father, in Scotland, and four brothers at Rockyford, Alta.

EDMONTON

Miss Isabel Raymond, formerly with the local Welfare Board, and recently with the Women's Hospital, New York, is spending a few weeks in the city visiting relatives before going to California.

Miss O. Watherston has gone to Peers as district nurse.

The following public health nurses were in the city for the Alberta Association of Registered Nurses' convention in November:—Misses Black (Vegreville), E. M. Davidson (Milo), M. Lavelle (Calgary), C. Lonsdale (Medicine Hat) and Thyne (Slave Lake).

Miss Smiley, assistant superintendent of the University Hospital, will take charge of the Provincial Orthopaedic Hospital which is to be opened early in 1928. Miss Gregg (Calgary General Hospital), who is at present on the staff of University Hospital, will be assistant superintendent of the Provincial Orthopaedic Hospital.

A most interesting lecture, with lantern slides, was given by Dr. S. McGibbon on the Vienna Hospitals to the G.N.A. at the November meeting.

Miss Amundsen, of the Isolation Hospital staff, has returned from a few months' vacation spent in Norway, Germany, France and the British Isles.

Miss Winnifred Golley has resigned from the Isolation Hospital staff and gone to Seattle.

Miss Oliver, of the operating room, Royal Alexandra Hospital, is holidaying in California.

BRITISH COLUMBIA

Results of examination for certificate and title of registered nurse held recently in various parts of British Columbia are as follows:—

Seventy-six wrote examinations in full, one candidate writing a supplementary.

Seventy-four (74) passed in the following order of merit:—

First class (above 80%)—Misses A. S. Cavers, Vancouver General Hospital; V. A. James, Vancouver General Hospital; P. M. Cox, Royal Columbian Hospital, New Westminster; M. L. Cowen, (M. Cahoon, O. Bealby) equal.

Second class (70-80%)—Mrs. M. E. Cox, Misses R. S. Cansfield, E. Patrick, D. Ramsay, K. Nield, (H. Biggam, C. A. Clare) equal, F. Wilkinson, E. Oliver, M. Morrison, (F. Lewis, M. Hopkins) equal, E. Fairhurst, S. M. Allan, C. Fortier, J. Yurick, M. Walker, L. Hendrickson, (M. Kays, M. Shoplans) equal, G. Way, D. Whittington, D. Collett, (A. Price, M. Crawford) equal, H. Peterson, E. Routly, G. D. McWhinney.

Passed (50-70%)—Misses M. Pynn, V. Towgood, L. Jones, G. I. Armson, (B. Jones, M. Parker, H. Pelly) equal, M. Barbour, (L. Bartlett, E. Innes, D. Mackay) equal, (H. A. Sackson, E. M. Webster) equal, L. Kearns, M. Cochrane, F. Donaldson, (B. Bittancourt, M. A. Reid) equal, (L. Dicken, G. Molyneux) equal, G. Blizard, E. Burgess, D. Jones, (R. Cranston, S. Ellis) equal, (H. Latham, E. A. Thrift) equal, L. Biggam, A. Owens, L. L. Routh) equal, (M. J. Craig, G. Elford) equal, A. Wallace, (W. Crossling, E. McLeod) equal, G. Carthew, A. M. Mitchell, M. Parfitt, L. M. Yates, H. M. Service.

Passed with supplemental to write—Miss P. C. May.

VANCOUVER

The annual meeting of the Vancouver Graduate Nurses Association was held in the auditorium of the Nurses' Home, St. Paul's Hospital, Vancouver, at 8 p.m., on November 9th, with the president, Miss

Ewart, in the chair. The minutes of the last meeting being read and business disposed of, an excellent entertainment was provided by members of the nursing staff of St. Paul's. Refreshments were served in the staff dining room, where a delightful social time was spent.

VICTORIA

In honour of Miss Isabel Jeffares, whose marriage to Mr. John Gibb took place in November, 1927, a tea was held by members of the Overseas Nurses' Club in Victoria.

The tables were prettily decorated with pink chrysanthemums and pale blue candles in pink sconces. The corsage bouquet which marked the place of the bride-elect was of pink rosebuds and maidenhair fern. Those present were: Misses Hodge, Ethel Morrison, Gregory Allen, Benvie, Naden, Franks and Mrs. A. E. Dixon. Mrs. Jeffares, mother of the bride-elect, poured the tea, and Mrs. Dixon cut the ices.

A pleasing incident was a shower, the gifts being presented in a large flower basket in pink and blue, thus carrying out the colour scheme of the tea table.

MANITOBA

BRANDON

The November social evening of the Brandon G.N.A. was held at the Welfare Station, when the members of the Association were guests of the public health nurses.

The regular monthly meeting of the B.G.N.A. was held at the General Hospital and the undergraduates had charge of the programme. Miss C. MacDonald read a splendid paper on Blood Transfusions, and Miss V. Kirbyson gave a very interesting paper on pre-operative preparation and post operative care of the patient.

Miss K. Campbell, Brandon General Hospital, 1923, has accepted a position in Dr. Templeton's office.

NEW BRUNSWICK

SAINT JOHN

A very interesting lecture on x-ray therapy was given by Dr. A. S. Kirkland at the November meeting of the Saint John Chapter of the New Brunswick A.R.N. in the Nurses' Home, General Public Hospital. Attendance was good and the nurses very much appreciated this instructive address. A hearty vote of thanks was extended to Dr. Kirkland. Routine matters were dealt with in a business session, and a social hour followed in which delicious refreshments were served.

Miss Ada Burns is a patient in the General Public Hospital for surgical treatment. Her friends will be glad to know that she is progressing favourably.

Miss E. J. Mitchell has resigned from the staff of the General Public Hospital. She has been matron of the hospital for a long period and will be greatly missed by all. Miss Mitchell's successor has not yet been appointed.

NOVA SCOTIA

Nursing Sister Laura Hubley (V.G.H.), who until recently has been on the staff of the Station Hospital, Halifax, has been transferred to the New Military Hospital, London, Ontario, and left for there this week. Miss Hubley has served as president, both in the Provincial and Halifax Branch of the Registered Nurses Association, and will be much missed in local nursing circles. During the past month many delightful social functions have been held in her honour, chief among which was a bridge given by Miss Flora Fraser, and a bridge and handkerchief shower by Miss A. E. Fenton. Mrs. Laurie Allison also entertained for Miss Hubley.

The Overseas Nurses' Club of Nova Scotia celebrated Armistice Day by a delightful dinner held at Ashburn Golf and Country Club. Covers were laid for twenty-seven guests. The banquet, which was later followed by a bridge, was a decided success. Miss K. McLatchey, matron of the Station Hospital, presided. During the evening telegrams were read from members who were unable to be present: among whom were Dr. Margaret Macdonald and Matron Pope.

Mrs. Reginald Melvin (nee Emma Thompson, V.G.H., 1916) is recovering from an operation at the Victoria General Hospital, Halifax.

Miss Elizabeth Miller (Newton Hospital, Newton, Mass.) has accepted a position with the V.O.N., Halifax. Miss Gertrude Mosher and Miss Maud Carter, Yarmouth Hospital, have also accepted positions on the V.O.N. staff, Halifax. Miss Carter was for the past two years night supervisor at the Yarmouth Hospital.

PRINCE EDWARD ISLAND

Examinations for registration of nurses were held recently throughout Prince Edward Island and the following nurses received certificates: Misses Isadora Gallant, Margaret McDonald, Edna Green, Mary Lowther, Marion Andrews, Lina Acorn, Elsie Mutch, Beatrice Hooper, Catherine Dalziel, Ila Collett, Lois Hardy, Maria Stavert, Edna Murphy, Catherine Woolner, Annie McKenna, Annie L. LeBlanc, Mary McCormac, Sr. Philip Neri.

The many friends of Miss Bertha Mason, secretary of the Graduate Nurses

Association, will be pleased to hear she has recovered from her recent illness.

Miss Marion Vickerson, a graduate of the Prince Edward Island Hospital, Charlottetown, is taking the Public Health Course at the University of Toronto.

Misses Eva Murdock and Grace Bishop have returned to New Rochelle, N.Y., after spending a pleasant holiday at their homes in P.E.I. They were accompanied by Miss Edith McNeill, who will do private duty nursing in New York for the winter.

Miss E. Compton has resumed her duties in Dr. Sinden's office, Park Ave., New York, after spending her vacation in Charlottetown.

Miss Mair, superintendent of P.E.I. Hospital, and Miss Fannie Kemp, of the "Polyclinic," have returned to their respective duties, after spending a very pleasant holiday in New York and Montreal.

Miss Marion Andrews (P.E.I. Hospital, 1927) has accepted a position in The Women's Hospital, Montreal.

Miss Lena Acorn (P.E.I. Hospital, 1927) is on the nursing staff of the R. B. Brigham Hospital, Roxbury, Mass.

The members of the Graduate Nurses Association very much regret the prolonged illness of Miss Lily Davison and Miss Florence Bowen.

QUEBEC

MONTREAL

The members of the Montreal Graduate Nurses Association held their fourth bazaar on November 21st and 22nd at the Ritz-Carlton Hotel. The bazaar was opened at 3 o'clock by Her Excellency, Lady Willingdon, who was received by Miss L. Phillips, president; Dr. F. Shepherd, and Miss E. Welch, convener. Miss Molly Wright, the little daughter of one of the nurses, presented Her Excellency with a bouquet of American Beauty roses. Lady Willingdon then visited the various booths and wished the nurses great success. The booths were in charge of the different Alumnaes of hospitals: Royal Victoria Hospital, miscellaneous; Montreal General Hospital, miscellaneous; Western Hospital, baby shop; Homeopathic Hospital, pantry shelf; Children's Memorial Hospital, handkerchiefs and novelties; graduates not connected with any Alumnae in Montreal, the linen shop; McGill graduates, candy; Women's Hospital, fortune telling and a really wonderful hope chest, the contents of which had been donated, was raffled and over $400 realized; the Public Health, beauty shop: a most popular feature; Overseas Sisters, a "floating old lady with a hundred pockets;" Lachine Hospital, housie-housie game, which gave great amusement. The Boy Scouts band rendered music both evenings. The Tombola was a great drawing card and made over $800.00. The Association is greatly indebted to the manager of the Ritz-Carlton Hotel, whose generosity, and that of his staff, made it possible for $5,555.00 to be added to the Nurses' Club House fund.

Western Hospital

Sincere and deep regret is felt by the members of the Association at the death of Miss Sarah E. Young, superintendent of the Montreal General Hospital Training School for Nurses. Miss Young took a great interest in the various activities of the Association and her loss will be genuinely mourned by all.

The annual bazaar and tea was held on Wednesday, December 7th, in the reception room of the Nurses' Residence of the Western Division of the Montreal General Hospital, and was very well attended by members and friends of the Association. The patronesses were: Mrs. J. C. Newman, Mrs. Wesley Bourne, Mrs. R. H. Craig, Mrs. Lorne Gilday, Mrs. C. C. Gurd, Mrs. F. B. Gurd, Mrs. R. Kerry, Mrs. Colin Ross, Mrs. J. A. Springle, Mrs. Wm. Reilly and Mrs. Bramley Moore. The conveners were as follows: General convener, Miss Byers; baby table, Mrs. Strickland; surprise package, Mrs. A. Barwick; homemade table, Miss M. Reyner; fancy work, Misses E. Payne and E. MacWhirter; candy, Miss N. Fletcher; tea, Miss B. Dyer; teacup reading, Miss C. Taylor. The sum of $500 was realized.

Miss Violet Cross had taken a temporary position in the operating room of the Western Division of the Montreal General Hospital.

Mrs. Frank Murphy (Anne Scullion), who has been residing in Maine since her marriage, has returned to Montreal with Dr. Murphy and will reside here indefinitely.

Women's Hospital

The Alumnae Association of the Women's Hospital, held their first meeting of the season in the Nurses' Home of the new building: the Women's General Hospital, 4039 Tupper St., Westmount. After the business meeting a reception was held in honour of Miss Isobel Thomson, who is leaving to reside in Vancouver. Miss Thomson has been one of the most popular and active members of the Alumnae and will be very much missed. She was presented with an overnight case as a small token of esteem from the members of the Association. Dr. Redely made the presentation and Dr. Burnett addressed the members.

Montreal General Hospital

It is with deepest sorrow the Alumnae Association realizes the passing of another much-loved member in the person of Miss Sarah Edith Young, whose death has followed so closely that of Miss Shaw and Miss Livingston, making the third great loss the Association has sustained within the past six months. Miss Young was first vice-president of the Alumnae and will be greatly missed as she always took such a keen interest in the affairs of the Alumnae, and especially in the well-being of each and every member. Miss Livingston, Miss Shaw and Miss Young were three stars in the profession, and brought further honour to the Montreal General Hospital. Their attainments are a worthy goal and ambition for each member of the Alumnae in their lives and work.

The following changes have been made on the staff of the Montreal General Hospital: Miss Martha MacDonald, 1927, has succeeded Miss Keneham, 1927, as one of the night assistants; Misses Helen Stewart, 1925, Margaret Gibbs and Janey Hayes, 1927, are engaged in floor duty; Miss Carrie Forbes, 1927, has accepted a position on the staff of the Outdoor Department, succeeding Miss Loita Best, 1927, who has taken charge of Ward "L;" Miss Hazel Miller, who has previously had charge of the floor, including "L" and "M" wards, will hereafter only have charge of "M."

Miss Helen DesBrisay has opened a convalescent home on Marlowe Avenue, Notre Dame de Grace, P.Q.

Miss Jane Bradley, 1927, sailed recently for Paris, where she intends doing hospital nursing.

The members of the Alumnae extend sincere sympathy to Miss Jessie Winns, 1927, in the loss of her father.

Miss Marion Ives, 1924, has gone to Labrador to take charge of one of the hospitals in Dr. Grenfell's Mission.

At the Montreal Graduate Nurses Association Bazaar held at the Ritz-Carlton Hotel on November 21st and 22nd, the total amount cleared was $5,555.00. The Alumnae booth, Miss Georgie Colley, convener, cleared over $1,000.

Mr. Whitfield Aston was unable to deliver an address as planned for the October meeting of the Association, so instead a pleasant musical evening was spent with the Baroness Chevesy, Miss Edith Ritchie and Dr. Fitzgerald as entertainers. At the November meeting Dr. Eleanor Percival gave a very interesting paper on Radium, while Miss Cramp, of Montreal, at the December meeting favoured the members with an entertaining lecture on "Three Centuries of Italian Art."

QUEBEC

The members of the Alumnae Association, Jeffery Hale's Hospital, are very pleased to hear that Miss C. E. Armour, lady superintendent of J.H.H., has recovered from her recent illness, and that Miss Mae E. Lunam, a member of the staff at the same hospital, is now convalescent.

On Armistice Day the Alumnae laid a wreath at the Cross of Sacrifice.

As a token of esteem and sympathy the members of the Alumnae sent a wreath of flowers to the family of Miss S. E. Young, of Quebec city, and late lady superintendent of Montreal General Hospital.

The following changes have occurred on the staff of the hospital: Miss Elizabeth Ford, 1912, has taken charge of the Douglas Wing; Miss F. Ascah, of Wards "D" and "K," and Miss Charlotte Kennedy, of Ward "O" (on the resignation of Miss Lenfesty).

Miss Mary Buckley, 1926, is on duty at Shawinigan General Hospital at Shawinigan Falls, P.Q.

Miss Marion Seale, 1926, is doing industrial nursing at St. Anne Power and Paper Co., at Beaupre, P.Q.

Miss Jennie Kennedy, 1921, is on duty for the Metropolitan Insurance Company in Quebec city.

Miss Gertrude Martin, 1925, won the scholarship and is attending the teachers' course, School for Graduate Nurses, McGill University, Montreal.

The marriage of Miss Edith Glass, 1918, will take place shortly.

ONTARIO

A paragraph in the "Nursing Times" of November, 1927, will appeal to those districts of the Registered Nurses Association of Ontario and the alumnae associations within them, which are relying upon their married members for support and leadership.

> "When a nurse gives up the active practice of her profession for marriage, or for any other reason, her experience of human nature and social conditions, are, too often, almost completely lost to the world outside her home. Yet experience of this kind is of the greatest value in such matters as housing, maternity and child welfare, and education, and indeed almost every department of public work, in which we should like to see ex-nurses taking a much greater share. We therefore congratulate Mrs. Stuart Shaw, the new mayor of Lichfield, who has accepted the office 'because, for the sake of the women she left, she had no right to refuse.' Mrs. Shaw is the wife of a local doctor, and was trained at the Edinburgh Infirmary."

The Red Cross Outpost Hospitals are a growing influence in the life of the province. The hospitals and nurses in charge now established are:—Apsley, Miss M. Taylor; Bancroft, Miss Marjorie Gall; Dryden, Miss E. MacEachren; Englehart, Miss Jessie Empey; Haileybury, Miss Dorothy Powers; Hornepayne, Miss Mary Sanderson*; Kirkland Lake, Miss Nita Rathbun*; Loring, Miss Grace Wilshire; Lion's Head, Miss Ida Brand; Nakina, Miss Myrtle Scott; Lady Minto Hospital, New Liskeard, Miss Agatha Gamble; Quibell, Miss Lucy Peters*; Richard's Landing, St. Joseph's Island, Miss Margaret Reid; Rainy River, Miss Barbara Easton; Thessalon, Miss Annie Nelson; Whitney, Miss Myra Rice*; Wilberforce, Miss E. Knaggs; Nolalu, Miss Katharine MacKinnon; Nipissing District, Miss Elsie Roper*.

*Qualified public health nurse.

DISTRICT 1

Miss M. Duffield, nurse in charge of the Victorian Order of Nurses, London, Ontario, has been transferred to the Vancouver district.

Miss Mary Shore has resigned from the Belleville district of the Victorian Order of Nurses to accept the position of superintendent of a missionary hospital on the Six Nations Reserve, near Brantford, Ontario.

DISTRICT 4

Miss Bernice Taylor has left Brockville and is with the Hamilton district of the Victorian Order of Nurses.

DISTRICT 7

Miss Louise Hendry has succeeded Miss Taylor in the Brockville district of the Victorian Order of Nurses.

DISTRICT 5

Toronto

A meeting of District 5 of the Registered Nurses Association of Ontario was held on Saturday, October 29, at the Ontario Hospital, Whitby. Over 100 members were present as well as representatives from Brazil, France, Roumania and Jugo-Slavia. A tour of inspection of the hospital was made and supper was then served in one of the attractive patients' dining-rooms. The meeting proper, which was held in the spacious recreation room, was addressed by Dr. George Stevenson, the new superintendent of the hospital. He spoke on trends in the treatment of mental conditions, tracing the development of the treatment from the early ages up to the present decade, with its well-built and well-equipped hospital replacing the "asylums" of the past centuries. He laid stress on the important part the nurse must play in the treatment of the patients and urged that more training in the care of such patients be included in each nurse's training. He emphasized the responsibility of the mental hospital not only for those within its walls but for the community as a whole. Follow-up for all discharged cases, and out-patient clinics should be established in order that the hospital may offer to the community a well-rounded service.

On October 27th the Department of Social Service of the University of Toronto entertained an interesting guest in the person of Countess Biondi, who was en route for Genoa, where she expects to help initiate training for public health nurses and social workers under the Fascisti regimé. The programme planned for her included visits to the Neighbourhood Workers' Association, the Social Service Exchange, the Department of Public Health of the University, and the Division of Public Health Nursing of the city. Considerable time was spent in the St. Clair District of the N.W.A. studying the co-operation between health and social workers. The countess speaks English fluently and was an exceedingly charming and interesting guest.

Miss Gladys Bastedo has resigned from the Nursing Division of the Department of Public Health, Toronto, to accept a position with the Canadian National Committee for Mental Hygiene. She has been assigned to the staff of the Toronto Research Division of the Committee and will assist in the study of children's behaviour now being carried on at Regal Road School. A year ago Miss Bastedo spent four months studying under Dr. Esther L. Richards at Phipps Clinic, Johns Hopkins Hospital, Baltimore.

Miss Hilda Volman has left North Bay to take charge of the newly opened district of the Victorian Order of Nurses at East York.

Toronto General Hospital: The regular monthly meeting of the Alumnae Association was held in the Nurses' Residence on December 7th. After the reports of the various committees had been received and the other business of the meeting dealt with, Miss Jean Browne read a most interesting and helpful paper on "Parliamentary Procedure," which was greatly appreciated by the members. The evening was brought to a close by the serving of refreshments.

Arrangements are being made to hold the Alumnae dance in Jenkins' Art Gallery on February 10th instead of February 14th, as previously announced.

Misses Betty McKague, 1924, Connie Leonard, 1925, Mae Wilson, 1924, and Amy Ruse, 1923, have joined the staff of the Rockefeller Hospital, New York.

Miss Gladys Reed, 1923, who has been in

Whitney Red Cross Hospital, has gone to Pasadena, California, for the winter.

Miss Vivian Lane, 1922, has returned to Detroit where she is doing floor duty at the Ford Hospital.

Miss Alice Nicholls, 1922, is in charge of the delivery room at the Women's Hospital, Cleveland, Ohio.

Miss Emma McKinnon, 1918, has accepted a position with the Social Service Department of the Toronto General Hospital.

Miss Charlotte Gardiner, 1922, and Miss Josephine Dickie, 1923, have returned from a six months' trip abroad and are at present in New York.

Miss Gladys Dauphin, 1918, is doing industrial nursing with the Harris Abattoir Co., Toronto.

Miss Dorothy Wright, 1921, is engaged in Child Welfare work in Winnipeg, Man.

Miss Nita Rathbun, 1922, who is in charge of the Red Cross Hospital at Kirkland Lake, is taking a short course in x-ray work in Toronto.

On November 18th graduates of the Toronto General Hospital who are at present in New York held a most enjoyable reunion which took the form of a tea. Those present were: Misses Helen Forgie, 1920, Helen Barnett, 1921, Muriel Berry, Helena Gunn, Beatrice Surder, Charlotte Gardiner, 1922, Dorothy Otton, Josephine Dickie, Astrid Anderson, 1923, Ruth Young, Georgina Howell, Eleanor Wheler, Barbara Kennedy, 1924, Morna Wallbridge, 1925, Ruth Carhart, 1926.

The annual tea and sale of work organized by the Occupational Therapy Department of the Toronto General Hospital was held in the Nurses' Residence on the afternoon of November 22nd. The display was in charge of the Misses Amy Des Brisay and Elsie Jacks, who are the instructors in this work. The handicraft was particularly attractive and included leather work in pleasing designs, embroidered wool bags, purses and handbags, fancy work, pretty lampshades and many other distinctive gift suggestions.

Hospital for Sick Children: Miss Reta Sutcliffe, 1917, has accepted the position of assistant to Miss Jackson in the local Victorian Order of Nurses at Ottawa.

Miss Ann Ingham, 1921, left in October for an extended trip abroad. Before leaving she was entertained by her classmates at a luncheon at the Casa Loma.

Miss Marion Ruddock, 1915, will spend the winter in California.

Miss Jessie Murdoch has accepted the position of welfare nurse with the T. Eaton Co., Toronto.

St. Michael's Hospital: Miss Katherine Clarkson, 1915, is a recent appointee to the staff of the operating room at St. Michael's Hospital.

Miss Mary Robinson, 1926, has been appointed to the position of public health nurse at Oakville, Ontario. Miss Robinson is a graduate of this year's class in Public Health Nursing, University of Toronto.

An event of great interest to all graduates of St. Michael's Hospital Training School was the celebration on November 21st, 1927, of the fiftieth anniversary of Sr. M. de Sales in the Community of St. Joseph. Solemn high mass was celebrated at St. Joseph's Convent by Monseignor Hand at which the clergy of the diocese of Toronto were largely represented. Later in the day Sr. de Sales was entertained at the hospital and was the recipient of many lovely gifts from her numerous friends. The Alumnae extended their hearty congratulations in the form of a gift of gold to one who is very dear to all members.

DISTRICT 8

Belleville General Hospital: Mrs. Cook (Bertha Goodwin) has just returned from England after spending several months with relatives.

Her many friends will be glad to learn that Miss Cockburn is able to resume her duties at the General Hospital after her recent operation.

Miss L. Davidson is taking a special course in Macdonald College, Guelph.

The sincere sympathy of the members of the Alumnae Association is extended to Miss Hilda Collier in the loss of her mother.

Miss Flossie Hannah is able to resume private duty nursing after an extended holiday owing to her health.

Miss Hull has returned from Lakefield, where she spent an extended holiday with her mother.

Miss Florence Fitzgerald has resigned her position with the Victorian Order of Nurses in Belleville.

We are pleased to hear that Miss M. Tait, former superintendent of the General Hospital, Belleville, has improved in health, and glad to know that she has accepted the position of superintendent at the General Hospital, Galt.

Miss R. Alford, who underwent an operation in the Belleville General Hospital recently, is progressing favourably.

Miss Cronk, night supervisor, Belleville General Hospital, had a very pleasant trip down east, spending her vacation with her father and sister.

Miss Bowen is in the Belleville General Hospital, having undergone an operation recently.

Miss H. Mastin has returned to Belleville and will take up private duty nursing.

Toronto Overseas Nurses' Club: A largely attended meeting of the Overseas Nurses Club of Toronto was held by the kind permission of Matron Hartley at the residence, Christie Street Hospital, on Friday evening, November 25th, with the president, Mrs. D. E. Robertson, in the chair. After the minutes of the preceding meeting had been read and adopted, the reports for the year were read. Activities included the laying of flowers on the cenotaph on Armistice Day, the presentation of flowers to the sick sisters, and the annual dinner. After a good deal of discussion it was decided that the club should meet more often during the winter months. This decision was very enthusiastically received and it was decided to hold a social meeting every second month, the date to be arranged by the executive. The election of officers for 1928 resulted as follows: Hon. president, Matron-in-Chief Macdonald; hon. vice-presidents, Miss Edith Campbell and Miss Hartley; president, Miss Maude Wilkinson; vice-president, Mrs. Ross Jamieson; corresponding secretary, Mrs. Ross Craig; secretary, Miss E. Drysdale; treasurer, Miss Agnes McIlwraith; executive, Misses Austin, Pat Tuckett, Cryderman, C. M. Graham, Whitlam, and Mesdames Hewitt, Bartholomew, Duncan, Jack, Bell, Ronaldson, Givens.

N/S Winnifred Godard is returning from China on a year's leave, coming via India and the Mediterranean. She expects to travel in Europe and also to attend Yale School of Nursing next summer.

Mrs. Mackenzie (N/S Isabel Lord) has returned to Shanghai on duty.

On November 7th, 1927, there passed away at the Queen Alexandra Sanatorium, London, Ont., Nursing-Sister Christina Stewart. Miss Stewart served with the Nursing Service of the Canadian Army Medical Corps during the war at Malta, Egypt, and the Dardanelles. She was a graduate of the Winnipeg General Hospital, class 1916. Interment took place at Miss Stewart's home, Almonte, Ontario.

CANADIAN NURSES ASSOCIATION

The biennial meeting of the Canadian Nurses Association will be held from July 3rd to 7th, 1928, in Winnipeg, Manitoba. It is expected that progress reports from the Programme and Arrangementts Committees will be available for publication next month.

Federated Associations are reminded that returns for nomination of officers, and payment of affiliation fees should reach the National Office, 511 Boyd Building, Winnipeg, Manitoba, not later than January 31st, 1928.

QUEBEC AND MANITOBA

The annual meeting of the Association of Registered Nurses for the province of Quebec will be held on January 30th and 31st, 1928, in Montreal.

The annual meeting of the Manitoba Association of Graduate Nurses will be held on January 26th and 27th, 1928, in Winnipeg.

Members of these provincial associations should see that they are in good standing and plan to attend all sessions of their respective meetings.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

ANDERSON—In May, 1927, to Dr. and Mrs. Anderson (Sadie Brockbank, Belleville General Hospital, 1924), a son.

BLACK—Recently, at Darlington, England, to Mr. and Mrs. Black (Francesca MacNeil, Montreal General Hospital, 1922), a daughter (Shirley Ann Frances).

COLLIER—In November, in Toronto, to Mr. and Mrs. Collier (N/S Bea Davidson), a daughter.

CROZIER — Recently, to Mr. and Mrs. William Crozier (nee Howard), a daughter.

DEWAR—On October 15th, 1927, to Mr. and Mrs. George Dewar (Jennie Kielby, Royal Victoria Hospital, Montreal), a daughter (Helen Kielly).

DYE—In November, to Mr. and Mrs. Harold Dye (Jessie Pinshin, Hospital for Sick Children, Toronto, 1921), a son.

FORBES—On September 16th, 1927, to Mr. and Mrs. John Forbes (Agnes Edgar, Stratford General Hospital, 1923), a son.

GILLESPIE—On November 17th, 1927, to Mr. and Mrs. E. L. Gillespie (Mary Middleton, General Hospital, Medicine Hat, 1921), a son.

MILLSON—On September 22nd, 1927, at St. Mary's, Ont., to Mr. and Mrs. W. G. Millson (Tena Rumble, Stratford General Hospital, 1924), a son.

MOLLETT—In September, 1927, at Allenford, Ont., to Mr. and Mrs. Chester Mollett (Doris Hearn, General and Marine Hospital, Owen Sound, Ont., 1924), a son.

MUSTARD—In October, to Mr. and Mrs. Alan Mustard (Jean Oldham, Hospital for Sick Children, Toronto, 1919), a son (James Fraser).

McNALLY — On October 29th, 1927, at Owen Sound, Ont., to Mr. and Mrs. Elmer McNally (Eva Rahn, General and Marine Hospital, Owen Sound, 1924), a daughter (Lenore Adelong).

PROUDE—On October 1st, 1927, at Charlottetown, P.E.I., to Mr. and Mrs. P. J. Proude (Winnifred McLean, P.E.I. Hospital, Charlottetown, 1922), a son.

PUTMAN—On November 22nd, 1927, at Montreal, to Mr. and Mrs. H. Putman (Sue Scott, Montreal General Hospital), a daughter.

STERNS—On October 24th, 1927, at Uigg, P.E.I., to Mr. and Mrs. Edison Sterns (Florence McKinnon, Moncton Hospital, N.B.), a son.

WALLACE—On November 15th, to Mr. and Mrs. Wallace (Doris Hammond, Hospital for Sick Children, Toronto, 1924), a daughter.

WILLOUGHBY—On November 29th, 1927, at Napanee, to Dr. and Mrs. J. D. Willoughby (N/S Florrie McCallum), a son.

MARRIAGES

ADAMS — BABCOCK — In April, 1927, Orpha Babcock (Belleville General Hospital, 1924) to John Adams, of Dunsville, Ont.

BURDEN—FEAR—Recently, at Springhill, Nova Scotia, Beatrice Fear (General Public Hospital, 1924) to James Burden. Mr. and Mrs. Burden will reside in Sydney, N.S.

CORRIGAN—RIDDLE—On October 26th, 1927, at Kirkwall, Ont., N/S Margaret Jane Riddle, R.R.C., to Dr. Matthew Poole Corrigan, of Strathroy, Ont. At home—Tara Hall, Strathroy, Ont.

DAKIN — HOYT — On November 12th, 1927, at Portsmouth, New Hampshire, U.S.A., Maida I. Hoyt (formerly night supervisor General Public Hospital, Saint John, N.B.) to Blair Dakin. Mr. and Mrs. Dakin will reside in Portland, Maine.

DOUGAL—JOHNSON—On October 28th, at Nanaimo, B.C., Euphemia Johnson (St. Joseph's Hospital, Victoria, B.C., 1912) to T. M. Dougal. At home—Chemainus, B.C.

DOUGLAS—WRIGHT—On May 8th, 1927, at Saint John, N.B., Mabel Wright (P.E.I. Hospital, Charlottetown, 1922) to J. L. Douglas, of Charlottetown.

FULLERTON—HIGGINS—On November 17th, 1927, at Saint John, N.B., Christian Higgins (General Public Hospital, Saint John, 1923) to Burgess Fullerton. At home—West Saint John.

HAINSLEY — GAUNCE — On December 2nd, 1927, Lottie Gaunce (Calgary General Hospital, 1923) to Roy Hainsley, of Empress, Alta.

HANLEY — BAWDEN — On November 26th, at Ridgetown, Ont., Ruth B. Bawden (Toronto General Hospital, 1918) to Dr. James Hanley. Dr. and Mrs. Hanley will reside in Lawrence Park, Toronto.

HOOD — SPADEMAN — On September 15th, 1927, Miriam Spademan (Women's College Hospital, Toronto) to Joseph Hood, of Toronto.

PARKER—GRANT—Recently, at North Bay, Ont., Beatrice Grant (Toronto General Hospital, 1922) to Joseph Parker.

GIBB—JEFFARES—On November 19th, 1927, in St. John's Church, Victoria, B.C., Isabel Marie Jeffares (Winnipeg General Hospital) to John Gibb, Duncan, Vancouver Island.

McINTOSH—COULTER — In September, 1927, Ruth E. Coulter, Belleville General Hospital, 1925) to James McIntosh.

McLEOD — MURCHISON — On August 17th, 1927, at Saint John, N.B., Grace Murchison (P.E.I. Hospital, Charlottetown, 1925) to the Rev. A. A. McLeod, Charlottetown.

JOHNSON—WETMORE — On September 15th, 1927, in St. James United Church, Montreal, A. Grace Wetmore (Montreal General Hospital, 1927), of Bloomfield Station, N.B., to Ralph S. Johnson, of Atlantic City.

McMILLAN—SANGSTER—In November, 1927, at San Francisco, California, Alice Maude Sangster (St. Joseph's Hospital, Victoria, B.C., 1927) to Mr. Norman McMillan, of Victoria. At home—San Francisco.

RAYMOND — SHUTTLEWORTH — On September 10th, 1927, Mary Shuttleworth (Hospital for Sick Children, Toronto, 1925) to C. Raymond.

ROY—MERRETT—In September, 1927, at Waterloo, Ont., Hilda F. Merrett (Hamilton General Hospital, 1925) to Stuart W. Roy, of Hamilton.

WEESE — BRADSHAW — In June, 1927, Olive Bradshaw (Belleville General Hospital, 1923) to Harold Weese.

DEATHS

HALIBURTON—In April, 1927, at Bonne Bay, Newfoundland, E. Haliburton (Jeffery Hale's Hospital, 1921).

HODGE—On October 7th, 1927, in Toronto, Elinor A. Hodge (Women's College Hospital, Toronto).

KNEESHAW—On November 17th, 1927, at Toronto, Florence R. W. Kneeshaw (Toronto General Hospital, 1926), daughter of Mrs. L. Kneeshaw, of Toronto.

STEWART—On November 7th, 1927, at Queen Alexandra Sanatorium, London, Ont., N/S Christina Stewart (Winnipeg General Hospital, 1916).

TRIMBLE — Recently, at Moose Jaw, Sask., Mrs. H. B. Trimble (Annie May Brooks, Brandon General Hospital, 1894).

YOUNG — On December 4th, 1927, in Montreal, Sarah Edith Young (Montreal General Hospital, 1900), superintendent of nurses, Montreal General Hospital.

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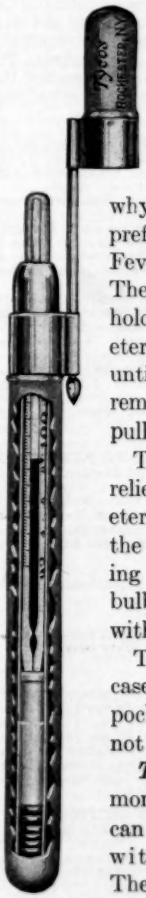

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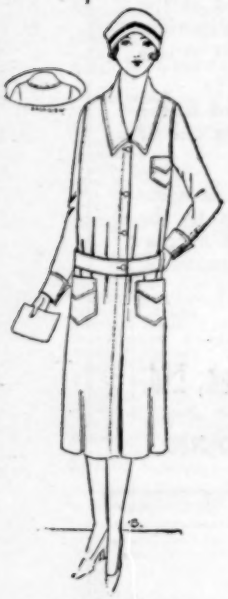

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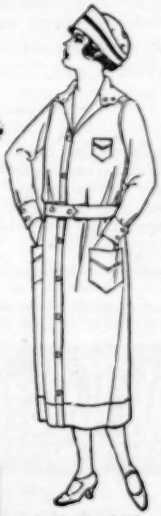

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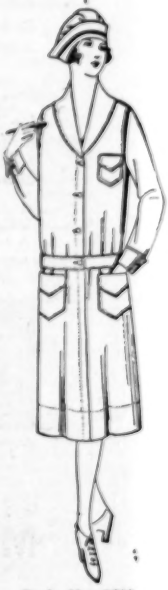

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FEBRUARY, 1928

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